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Introduction

The 2001-2005 Pittsburgh/Allegheny County Healthy Start Impact Report summarizes our efforts on infant mortality, low weight birth and very low weight birth reduction and the elimination of perinatal health disparities with comprehensive strategies directed toward reducing related medical and socio-demographic risks.

I. Overview of Racial and Ethnic Disparity Focused on By Project

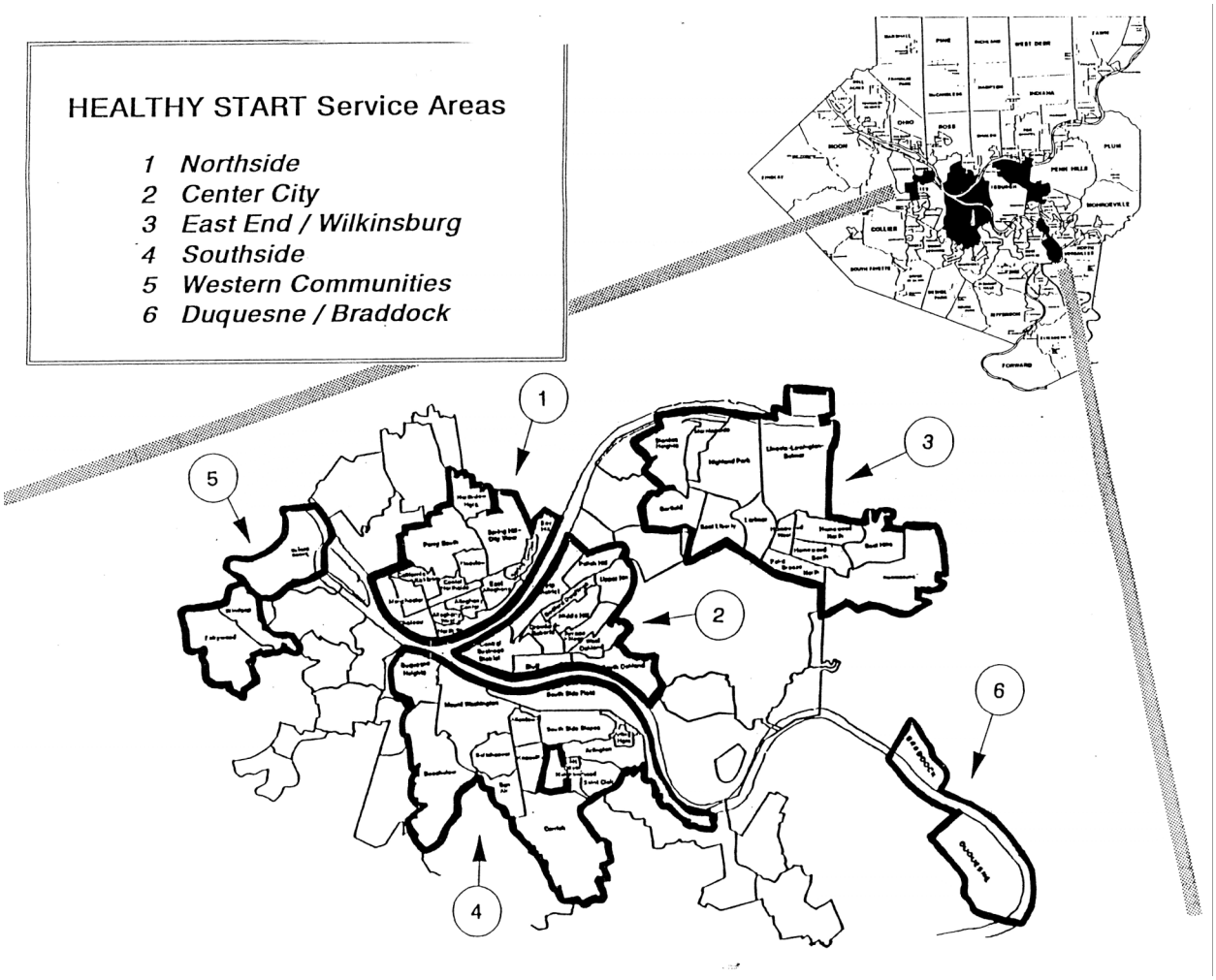
The site of a prestigious medical center, Pittsburgh, Pennsylvania is also the city where an African-American infant has less chance of surviving the first year of life than in most other major American cities or, for that matter, in many third-world countries and where a white infant born in a high risk neighborhood fares almost as poorly.

Initial community needs assessment overview:
The Healthy Start/Pittsburgh and Allegheny County Project Area encompass six Service Areas, primarily within the City of Pittsburgh but including four municipalities in Allegheny County, outside the city. Of the city's 88 distinct neighborhoods, 45 are included in the Project Area. Together, these communities represent:

- One sixth (17%) of the county's and half (51%) of the city's total population
- Two-thirds (67%) of the African Americans residing in the county and 89% of those in the city
- Nearly half (43%) of the infant deaths occurring in the county and virtually all (93%) of those in the city

By any measure, the Healthy Start communities are at high risk for infant mortality. If the births within the Project Area during 1990:

- More than one-third (36.3%) of the mothers reported annual household incomes under $5,000, and more than half (51%) were living on less than $10,000. (In Center City, these figures are 56% and 73% respectively)
- One-fifth (20% of the births (compared to 12.5% nationally) were to teenagers, and nearly one fourth (23.2%) of the mothers had less than a high school education
- Nearly two-thirds (64.5% of the births were to single mothers (The percentage rises to 83.6% in Center City)
- The rate of low birthweight (under 2,500 grams) was nearly twice the national average (12.2% vs. 6.9%)
- Fewer mothers had sought prenatal care during the first trimester (66.1% vs. 75.1% nationally) and more (10.3% vs. 6.5% nationally) received care only in the third trimester or not at all



This heightened risk profile is dramatically reflected in the infant mortality rates. Despite the fact that the 1990 white infant death rates for Allegheny County as a whole (5.8), for Pittsburgh (5.2), and even or the Project Area (6.5) are significantly below the national rate (9.4%), the rate for nonwhite infants in all three area (23.1, 23.6, and 24.7 respectively) are approximately 1.5 times the national rate of 18.6. ["Nonwhite" in Allegheny County and Pittsburgh is predominantly African American; other minorities (chiefly Asian) comprise less than 2% of the city population, one percent of the county population and a negligible number of infant deaths.]

Although minorities comprise only 12.5% of the county and 27.9% of the city populations, the disproportionately high nonwhite infant mortality rate inflates the overall IMR for both jurisdictions (9.3 for the county, 13.2 for the city) and the Project Area (17.8) to a figure above the nation average for all races (9.1).

Indeed, the Project Area's overall IMR (17.8) –for a population that is 57% white-is only slightly lower than the U. S. rate for nonwhite (18.6), The Project Area nonwhite IMR is 26.3. [1990 Census]

The high nonwhite IMR and its impact on the overall rate is not an artifact of 1990 data. The three-year average (1988-90 detailed in the need assessment shows an even higher (19.8) overall rate for the Project Area, and the county and city rates have consistently been approximately 11 and 15 for the last six years. The mortality rate for nonwhite (principally African American infants in the city has exceeded 30/1000 live births five times during the last two decades, repeatedly earning for Pittsburgh the dubious distinction of ranking among the highest cities nationally in African American infant mortality. At no time since 1971 has this rate dropped below 20/1000 live births.

The "Healthy People 2000" goals established national targets in a number of health risk areas pertaining to women, infants, and children that related directly to Health Start objectives. Specifically, with regard to infant mortality, Healthy People 2000 goals proposed to reduce:

- overall infant mortality to 7 per 1,000 live births
- mortality among African American infants to 11 per 1,000 live births

By 1990 data standards, the rates for white infant deaths in Allegheny County, Pittsburgh, and the Healthy Start Project Area were slightly below the 1990 goal for white infants; however, for the three-year average (1988-90), the local jurisdiction and particularly the Project Area lagged far behind the 1990 goals.

It should be noted that, although Project Area African American infants are nearly three times as likely as their white counterpart to die during the first year of life, the white IMR is also high in several service areas. In the Western communities, for example, the white IMR is slightly higher than that of African Americans: 21.3 vs. 20.4. In the South Side, where 73% of the births are white, infant mortality rates are high for both races: 3.18 for American Americans and 12.0 for whites.

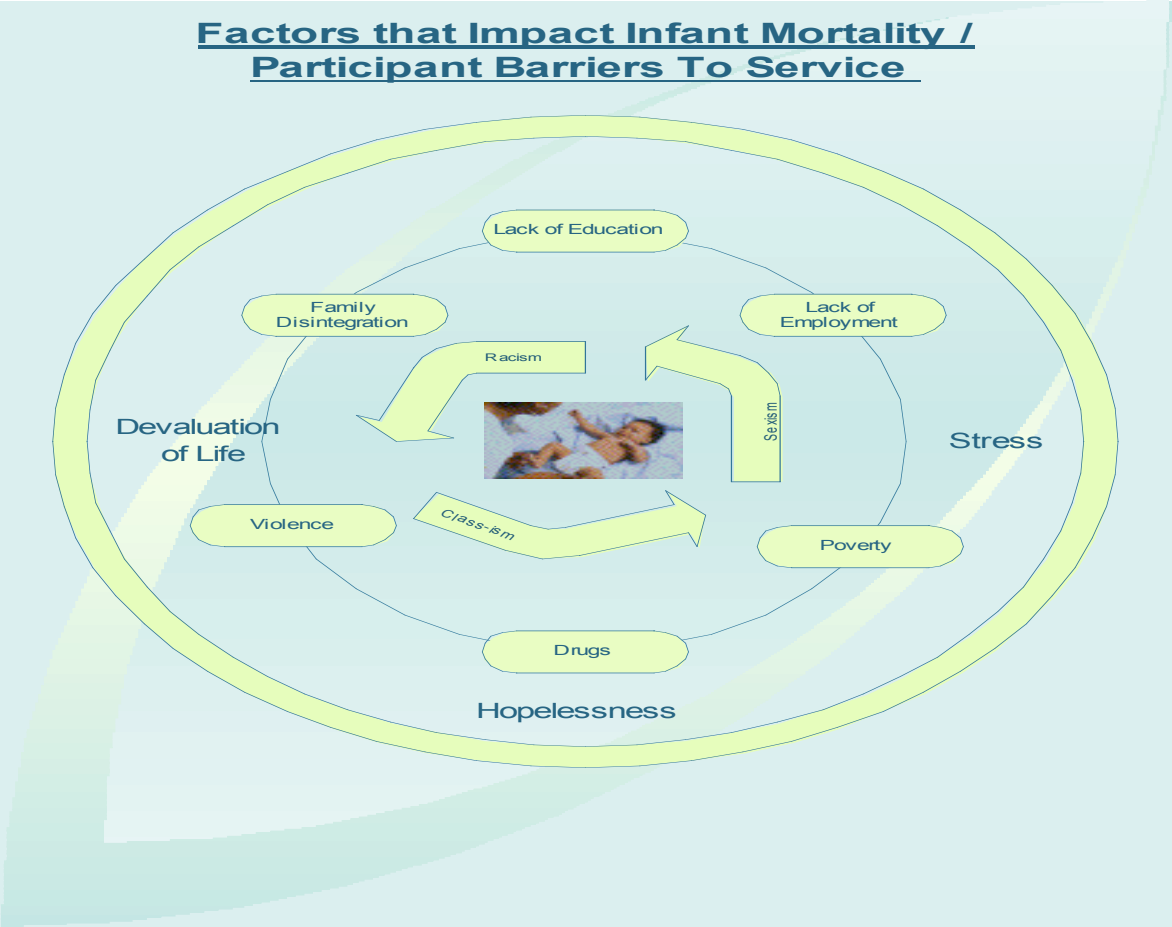
Infant mortality rates in the county had declined, albeit irregularly, over the last two decades (from 21.1 and 16.9 respectively in 1975 to 13.2 and 9.3 in 1990), but the decline had occurred chiefly as a function of the sharply dropping mortality among white infants (from 15.3 and 13.7 in 1971 to 5.2 and 5.8 in 1990). Non white Infant Mortality Rates dropped only about 5 points (from 29.3 and 27.2 in 1975 to 23.6 and 23.1 in 1990). Assuming the continuation of this trend, a steadily widening racial gap by the year 2000 was predicted.

The ratio of white to nonwhite infant deaths in the city of Pittsburgh increased from 1:2 in 1975 to 1:4.5 in 1990. Projecting this trend over the next decade, without additional intervention, predicted not only a failure to reach the Healthy People 2000 goals. It also projected a racial gap of 1:7.

Not content to allow the data alone to define the problem, the planning team sought input from the community through three forums and six focus group interviews. In addition, the team reviewed the findings from six additional focus groups conducted for the Jewish Healthcare Foundation and reported in its infant mortality study, Ear to the Ground (1992).

Participants, all of whom were from the Healthy Start Project Area, identified the following as factors contributing to infant mortality:

- Insensitivity of health care providers
- Racism, classism, and sexism in the community at large
- Limited potential for economic advancement, particularly for African American males
- Poverty and unemployment
- Lack of transportation
- Inaccessible services
- Lack of effective outreach by providers who are removed geographically and socially from the communities they seek to serve
- Failure of individuals and society to value each other and, particularly to prioritize the well being of children
- Substance abuse
- The need for an entity that would streamline administration and be culturally appropriate and sensitive to the needs of the individuals being served. And at some point in the future stand alone separate and distinct from the Health Department, which is a unit of local government.



In 1991, Pittsburgh/Allegheny County, Pennsylvania faced clear challenges. How to reach the Healthy Start goal of a 50% reduction in infant deaths by 1996 and in 2001 how to eliminate health disparities and most recently how to reverse the cycle of an ever-widening gap between the races in these important health status indicators.

At the onset, experts determined that it required a comprehensive and intensive community-wide effort: The Pittsburgh/Allegheny County Healthy Start Initiative.

Renee's Story. . .

Renee is a 19 year old African American pregnant for the third time. She hasn't had a pregnancy test, but she knows the symptoms, and she has them all. She's been there before-when she was carrying Michael, who is 18 months old now, and she lost her second child who was born prematurely.
.....She remembers the attitude of the clinic staff when she went for prenatal care the first time…. She's in no hurry now to go back to that clinic. She'll simply go to the emergency room if she really feels sick, like she's always done.
She's not very happy about this baby. For that matter, she's not very happy about herself……
After Michael was born, she went on welfare and moved into her own place. She felt alone and alienated…..She had looked for work, of and on, but the only job she could find paid minimum wage: part-time in a fast food restaurant. But....she could not afford to give up her welfare, pay more rent, pay for day care and lose her Medicaid coverage, so she gave up. She could get by on her welfare check.
She has used drugs occasionally and knows it is not good for her baby. In fact, drugs might have contributed to the death of her second child. But that was the only escape she had from the drudgery of her life.
Then Frank came along…..Sometimes he had money and when he did, he was very generous. He refused to work for minimum wage…..called it a life for suckers. He didn't tell her where the money came from, and she didn't ask. But she worried about him.
……Frank didn't know about the new baby yet. She wondered when to tell him. She knew it would put a strain on their relationship.
Renee wants a better life, for herself and for Michael. She started going to church to find some direction. But the people send aloof and indifferent. She hasn't been back recently.
Sometimes she thinks about her dream, at 16, of becoming a nurse. Now she's just overwhelmed by the daily demands of her life….Her mother's admonition - "Make something of yourself" – grows louder and louder. But how?

Renee was the model for the design of the Pittsburgh/Allegheny County Healthy Start plan, and she remained the focus of our attention as we move into the tenth year of operation…

For her own sake and that of her children, one of them not yet born, Renee needs quality sensitive health care.

Our Multidisciplinary Core Teams see that she gets it-before and after her baby is born. And they find other services she and her children need…..pediatric care, mental health counseling, housing assistance, a supportive parenting program, health education, job training and childcare.

Much of the help that Renee needs, so desperately, she finds in her own community, through service that are selected, promoted and monitored by her neighbors who served on one of the six Regional Consortia.

Through it all, from the news media, volunteers, professional and paraprofessional staff, Renee hears and feels the community's concern for her and knows that her life and her children's lives are valued…..Healthy Start's goal is to help Renee take charge of her life…to make something of herself, in her words. Healthy Start is here to show her how.

II. Project Implementation

The organizational framework for the Pittsburgh/Allegheny County Healthy Start program is designed to support the comprehensive, consumer-driven approach of the project. It's systemic and interactive in nature; that is, it provides for the involvement of community representation at all levels in the planning and implementation process. All organizational components-policy formulation, management and operations, and service delivery-are linked to ensure that all management and program initiatives are responsive to the social-psychological realities of the at-risk client.

Outreach and Client Recruitment

A.

The Pittsburgh/Allegheny County Healthy Start Outreach and Client Recruitment core service rationale is based on addressing perinatal health, women of childbearing age (10-44), inclusive of all infants and toddlers up to two (2) years of age, fathers/male partners and caregivers of infants residing in the project area and Allegheny County. Specific targeted populations include pregnant women who are at risk for poor pregnancy outcomes (i.e. Medicaid recipients, the uninsured, the underinsured, victims of domestic violence, adolescents <15 years of age, substance abuse addiction, medical/mental health conditions, and women who smoke during pregnancy).

Pittsburgh and Allegheny County has for years had infant mortality rates exceeding those of other major U.S. Cities. On eight occasions, between 1970 and 1982, Pittsburgh ranked among the Nation's three worst cities for black infant mortality. On half of those occasions, Pittsburgh had the highest rate of infant mortality among African-Americans than any city in the United States.

In 1991, when the Allegheny County Health Department implemented the Healthy Start Initiative, specific neighborhoods of the City of Pittsburgh and surrounding municipalities within the county were selected to concentrate resources and efforts towards the population where problems were occurring.

The Pittsburgh/Allegheny County Healthy Start implementation plan focused on providing a comprehensive community-driven approach to address infant mortality in the six regions that comprise the Project Area. A new service expansion throughout the county was implemented in 1999 for all high-risk referrals of women and infants. The plan incorporated the Healthy Start Community-based Consortia organizational model and combines two service intervention models, Outreach and Case Management, that address the needs and problems identified, and provides the proven effective strategies for impacting infant mortality.

The Pittsburgh/Allegheny County Healthy Start Project Area encompasses six Service Areas, primarily within the City of Pittsburgh including four municipalities in Allegheny County, outside the city. Of the cities 88 distinct neighborhoods, 45 are included in the Project Area. Together, these communities have been identified in a number of previous studies as those at highest risk for conditions that negatively affect pregnancy outcomes. In the Healthy Start Project Area (2000-2002) there were a total of 13,397 live births: 61.9 percent (5487) of the live births was African American while 38.1 percent was white and nonwhite.

For the three-year period (2000-2002), the Project Area accounted for one-half (49.9%) of all infant deaths in Allegheny County. The Project area accounted for over three-fourths (75.78%) of all African-American infant deaths in Allegheny County.

While participants resided in target areas, they continued to encounter numerous logistical and psychosocial barriers to prenatal care, including high poverty, high rates of inadequate health insurance, health care provider shortages, transportation problems (both access and travel distance), as well as health and human services systems that have been inadequate to the myriad needs of the poor and low-income. Special efforts and interventions put an emphasis on women, men and infants/children who were African-American and those who experienced disparate health care and human service benefits due to low socioeconomic status. To overcome these barriers, the Pittsburgh/Allegheny County Healthy Start program has sought to effect change in individuals and families, in the health care provider environments and in the health systems on which they depend.

B.

Pittsburgh/Allegheny County Healthy Start personnel and resources needed to implement interventions begin with the Healthy Start 24-hour Helpline. This is the primary point of entry into Healthy Start and serves as a vehicle to provide valuable resource information. An Information and Referral Specialist II staffs the Helpline and is responsible for completing the initial contact form during phone calls. After obtaining the participant's approval/consent, they schedule the initial home visit within a 48-hour time period. While the Information and Referral Specialist staffs the Helpline from 8:00 a.m. to 5:00 p.m. daily, the phone answers 24 hours a day. After hours, an answering service takes names and telephone numbers of callers and the Information Referral Specialist returns the call within 24 hours.

The Outreach Enrollment and Assessment (O.E.A.) Team traveled throughout Allegheny County promoting the importance of early prenatal care, utilization of family planning and primary care services, providing maternal and child health education and increasing enrollment in Healthy Start programs. Their activities included: community outreach and recruitment, and aggressive outreach for hard-to-contact participants; intake and enrollment for new participants; completion of initial risk assessments for pregnant women, postpartum women, fathers and their children; and identification of community resources for referrals.

During the initial enrollment visit, the Outreach Worker has always ensured confidentiality, explained the Healthy Start program services to all participants, secured required consents and authorizations, completed a maternal health history (female), service agreement (male), initial risk assessment and collected information on whether or not a participant had a medical home and/or health insurance. An assigned Field Manager completed Quality Assurance for new enrollment charts. Charts then transferred to the Healthy Start multidisciplinary team for case management. Healthy Start Field Manager(s) have been responsible for the day-to-day supervision of 16 full time outreach workers and the Executive Director has provided oversight.

Healthy Start's home visiting multi-disciplinary team has built close participant relationships that are crucial for interventions. The program has made every effort to ensure cultural and linguistic appropriateness. Helping interventions included scheduling visits at convenient times for participants and being consistent with visits, making reminder and follow-up calls for appointments and referrals, transportation services, developing personal referral networks, staying flexible, leaving door reminders whenever participants are unavailable, maintaining confidentiality, being non-judgmental, respecting their values and displaying a truly caring attitude. Additional strategies to address interventions:

- Hired indigenous community-based outreach workers (82% of Pittsburgh/Allegheny Healthy Start staff lives in the Project Area Communities)
- Regional offices located within the Healthy Start communities
- Facilitated transportation and childcare
- Established a Children with Special Healthcare Needs referral network
- Established linkages with a broad array of health and human service providers through ongoing referral network collaborations
- Continued follow-up on medical appointments as well as all referrals
- Extensive training of program staff and regional consortium members as well as other program/agencies providers on topics such as Cultural Competency among others
- Provided intensive case management services to adolescents, families affected by substance abuse and women who are experiencing depression

Linkages and coordination of outreach services utilized a three-prong approach that interfaced with other agencies and organizations within our targeted communities. The main responsibility fell to the Perinatal Systems Liaison (PSL), whose duties included attending meetings, making presentations and promoting Healthy Start services.

Secondly, the outreach workers have taken the most critical steps in the engagement process with program participants, and what has occurred at the first assessment ultimately determined whether a participant would engage further in case management services. The Team interfaced with participating hospitals, private practice physicians, family planning clinics, business, human services providers and community health centers developing a personal referral network for program participants.

The Team targeted outreach and recruitment of male and female program/community participants by making program information available to community service outlets. All outreach and recruitment materials contained the Healthy Start logo and the Helpline phone number. Outlets such as barbershops, beauty and nail salons, clothing stores, community events (health fairs, job fairs, etc.) playgrounds, community recreational centers, laundromats, local football, baseball and other youth sports programs were utilized.

Consortia members, who continue to be the gatekeepers of the community, assisted recruitment by identifying potential female and male program participants. Consortia members have been instrumental in keeping community residents knowledgeable and updated on the program. Their key role as the "voice" of the community has promoted the Healthy Start mission by reducing infant mortality and eliminating health disparities.

The Healthy Start Perinatal System Liaison (PSL) along with the Consortia has assisted the Team in identifying community participants for program participation and hosted community events such as clothing drives and health education series. In addition, consortia members hosted annual community baby showers. Baby showers have been an intervention that Healthy Start utilized to enroll and recruit pregnant or post partum women. Healthy Start also sponsored and participated in national promotions and community events.

The Team developed on-going community-driven participant relationships with area schools, faith-based organizations, local community health centers and hospital outreach programs. Another productive recruitment method has been continued collaboration with community-based medical centers, non-profit organizations and family support centers.

The implementation of multi-disciplinary community based agency teams have utilized and nurtured collaborating relationships with single focus at-risk population community-based programs. Those area(s) included smoking cessation, fatherhood initiative, school based prevention programs, residential/ outpatient substance abuse treatment facilities, jail initiative programs for women and men among other services.

The Team hosted monthly Family Focus Nights which were open to program and community participants. Family Focus Nights are interactive group activities (2000-2004 /48 sessions/ 483

participants) that offered an evening of discussion and reflection based on a family or character-building topic. Family Focus Nights provided a safe environment allowing

participants to communicate and process positive information and incorporate it into a healthy lifestyle plan of action.

The Marketing Committee has been composed of board members and consumers who reviewed all material utilized for health messages, brochures, flyers and educational material to insure it met the appropriate 4th grade reading level. They also ensured that the information was culturally sensitive and that it addressed the needs of the Healthy Start communities at large. Programmatically the project periodically conducted surveys and focus groups for participants to gain input that addressed program needs and improvements.

Community awareness and name recognition of Healthy Start, Inc. has been ongoing. The Team has conducted consistent outreach and recruitment activities including aggressive community outreach such as the distribution of culturally sensitive brochures, flyers and pamphlets, neighborhood-canvassing (door- to-door) to locate at-risk women, fathers and their families in the Healthy Start project area. They were able to identify and enroll new program participants during health fairs, health and human service provider conferences and fatherhood forums. Participation in job fairs and community days were also part of the strategy as along with extensive Public Service Announcements (PSA) on local radio stations. When canvassing neighborhoods, outreach workers have always worn Healthy Start uniforms, (monogrammed baseball caps, umbrellas, attaché cases, blue shirts and khaki pants) so as to be easily identified.

Other successful interventions have included the promotion of the Healthy Start Helpline and the telephone number is on all handout materials. These include items such as enrollment bags, magnets, pencils, ink pens, rattles, immunization magnets, choke tubes, bibs, ear thermometers, fever forehead scans, infant/toddler tee shirts and on health education messages, pamphlets, brochures, newsletters, fact sheets and all printed materials.

Ongoing efforts included individualized health education during home visits, referrals and care coordination, aggressive follow-up and public education. Information has been disseminated through the media and Healthy Start newsletters and publications. The types and number of contacts made during outreach interventions have been the following:

- 47,532 women of childbearing age received enrollment information, referral services and breastfeeding referrals through the Helpline
- -19,861 families received flyers, pamphlets and door knockers during community canvassing
- -1390 age appropriate health screening schedules disturbed to community/program participants, local business, health and human services

C.

One of the greatest challenges for the successful initiation and implementation of outreach and recruitment has been the ever changing demographics within the Healthy Start communities. Allegheny County closed or downsized several public housing communities that were physically located within Healthy Start neighborhoods. In addition, the transient nature of our population has also proved to be a challenge.

Another challenge has been participant availability. Participant employment and/or school hours have been affected by Pennsylvania's Welfare Reform Initiative, "Welfare to Work". The impact of welfare reform and the requirements that mothers join the workforce has hindered our ability to enroll our families and even precluded some who were interested from participating in the Healthy Start program. Unfortunately the populations most-at-risk have also faced a tremendous challenge in understanding and adjusting to the changes that have occurred and will continue to occur in the future. We have also seen declines in the utilization of healthcare including prenatal and well baby visits for working mothers and their babies. Healthy Start has attempted to intervene and assist, but budgetary and programmatic cutbacks diminished and diluted our efforts and the system issues have been overwhelming.

Families struggled with childcare, the availability of childcare with varying hours and the adequate numbers of facilities for those newly returning to work presented obstacles to our families. In addition the quality of childcare was also an issue.

In some cases, community perception, prior treatment experiences, the shortage and/or lack of minorities in the work place have proven to be barriers. Personal substance abuse issues, mental health issues, such as depression, homelessness, domestic abuse or poor housing environments have continued. All of this has had an impact on our communities, but if we add the distrust of the health and human service system, participation in many programs is made even more problematic. Other retention barriers may be that women and men are just not ready to change the poor/unhealthy lifestyle/behavioral habits, such as smoking or illicit drug use because of the influence of family members and/or friends.

Case Management

A.
The countless difficulties that exist in disparate populations in Pittsburgh/Allegheny County areas stimulate a great deal of need for persons to utilize the health care and human service system. The cultures of the program and community participants served by Healthy Start Inc., 85% of which are African American, tend to underutilize the availability of such services for reasons listed, but not limited to access to care, ethnic intimidation, and general mistrust of treatment providers. Additionally, the system itself is fragmented by a specialization of services that requires participants and families to contact multiple social agencies, as well as surmount system navigation barriers in order to have their needs adequately addressed.

In 1991 a study conducted by the United Way of Allegheny County looking at early childhood and parent support strategies found that, "the health and human service system is fragmented by a specialization of services that requires families and individuals to contact multiple social services agencies, surmount bureaucratic and geographic barriers in order to have all of their needs addressed." In response, Healthy Start Pittsburgh/Allegheny County developed a coordinated service model of Outreach, Case

Management, and Facilitating Services to address these issues and provide women and children with better linkages to health and human enabling services. As of November 2004 Healthy Start Inc. has provided case management services to over 11,150 women, 1,500 fathers and 7,230 infants.

In 1997 Healthy Start reviewed the effects of the original case management model and determined that it was effective, however, found that changes needed to be made to meet the demands placed on program and community participants by Welfare Reform. Particularly pressing were the available time and training restraints placed on women to get off of welfare and into the employment sector. With those changes came specialized case management services within Healthy start including mental health, young adolescents and substance abuse specialists. As a result Healthy Start was more effective at promoting behavior change and increasing positive outcomes for women and children. In fact, the infant mortality rate for the project area steadily decreased from inception until now.

From 1997 to 2000 Healthy Start weathered many more changes including a loss of the financial support that enabled outreach and case management programs to exist. Due to these losses Healthy Start Pittsburgh again modified its' approach to meet the needs of the community. Utilizing the guidance of the Consortia, Healthy Start Inc. expanded its scope of services holistically, providing services to meet the needs of the entire family. In conjunction with the Male Initiative Program and the specialty programs related to substance abuse, teens and mental health, Healthy Start was able to provide a truly multidisciplinary approach to outreach and case management.

From 2000 to present Healthy Start Inc. remained challenged by both the systemic changes like those of Welfare (TANF) Reform and the decreasing federal dollars. Systems evolved towards a "one-stop-shop" team approach aiming to make more timely impacts on a family utilizing specialized staff and then using the community agencies such as Federally Qualified Health Centers and Family Support Centers as long term support frames. While the scope and delivery of services has been flexible, the impacts and accomplishments achieved remain unwavering.

B.
The service model of case management was developed to provide participants with access to a host of enabling services and programs while ensuring that participants and their families are not lost to, or within, the system. Ensuring cooperation and understanding of these systems significantly impacts the health and welfare of children, youth, and families. This is especially evident in the steady decline of infant mortality rates and low/very low weight births not only for Healthy Start, Inc. program participants but in the entire project area.

Case management includes assessment of participants' needs, interests, and risks; strengths-based and consumer-driven planning; community-based service and/or referral coordination; monitoring; education; counseling; and regular reassessment. A Plan of

Care (POC) serves as a guide to achieving a high sense of self-worth and an ability to take personal responsibility for their well-being.

Services are provided via "Home Visits" and to the most at-risk population ensuring that timely perinatal prevention and intervention produce positive outcomes. Remaining committed to eliminating health disparities, case managers guide participants through the various systems, while building trust in the community providers. These two major principles are the core of an effective approach to case management.

Central to Healthy Start's case management is the commitment to deliver referral, maintenance, prevention, and intervention services through the Multidisciplinary Team approach. Teams servicing distinct locations within Pittsburgh's communities are made up of a Core and/or Male Initiative Program (MIP) Outreach Worker (OW), Registered Nurse (RN), a Bachelor of Social Work (BSW), a Licensed Social Worker (LSW), Clinical Coordinator, Male Program Specialist, and a Field Manager (FM). Assisting the team are the Information and Referral Specialist, Program Assistant/Data Abstractors (PA/DA), and an Administrative Assistant. As a whole they work together to assure that women, men, children and their families secure access to the medical care and human services necessary to promote healthy family lifestyles.

Home visiting, as the primary method for delivering case management services, generally last 45 to 75 minutes. This holistic approach to home visits expanded coordination and corresponding referral services for entire families. Since 2001, home visits have averaged 10,000 per year with those numbers increasing due to the addition of a Licensed Social Worker for behavioral health support services.

Case management has diversified over the years to assure that "specialty" populations receive targeted services. Currently, HS has three specialty teams providing care coordination to women with substance abuse problems, adolescents 15 years and younger, persons with mental/emotional/behavioral issues and fathers/male caregivers as evidence through the Male Initiative Program (MIP).

An average of 32% of births in Allegheny County was born to unmarried women during the three-year period 2000-2002. Healthy Start Inc.'s MIP program targets fathers who are most at risk of becoming a detriment rather than a positive and influential member of a child's life.

The "typical" MIP father is 22 years old, African American, unmarried, unemployed or works part time, has a 10^{th} grade education, needs sustainable housing, has no health insurance coverage (less than 35% in 2003; Case Management Records) and is experiencing family separation/division problems. He likely has fathered two or more children to different mothers. Healthy Start fathers and male caregivers are more likely to use alcohol, tobacco and other drugs to cope with psychosocial stressors.

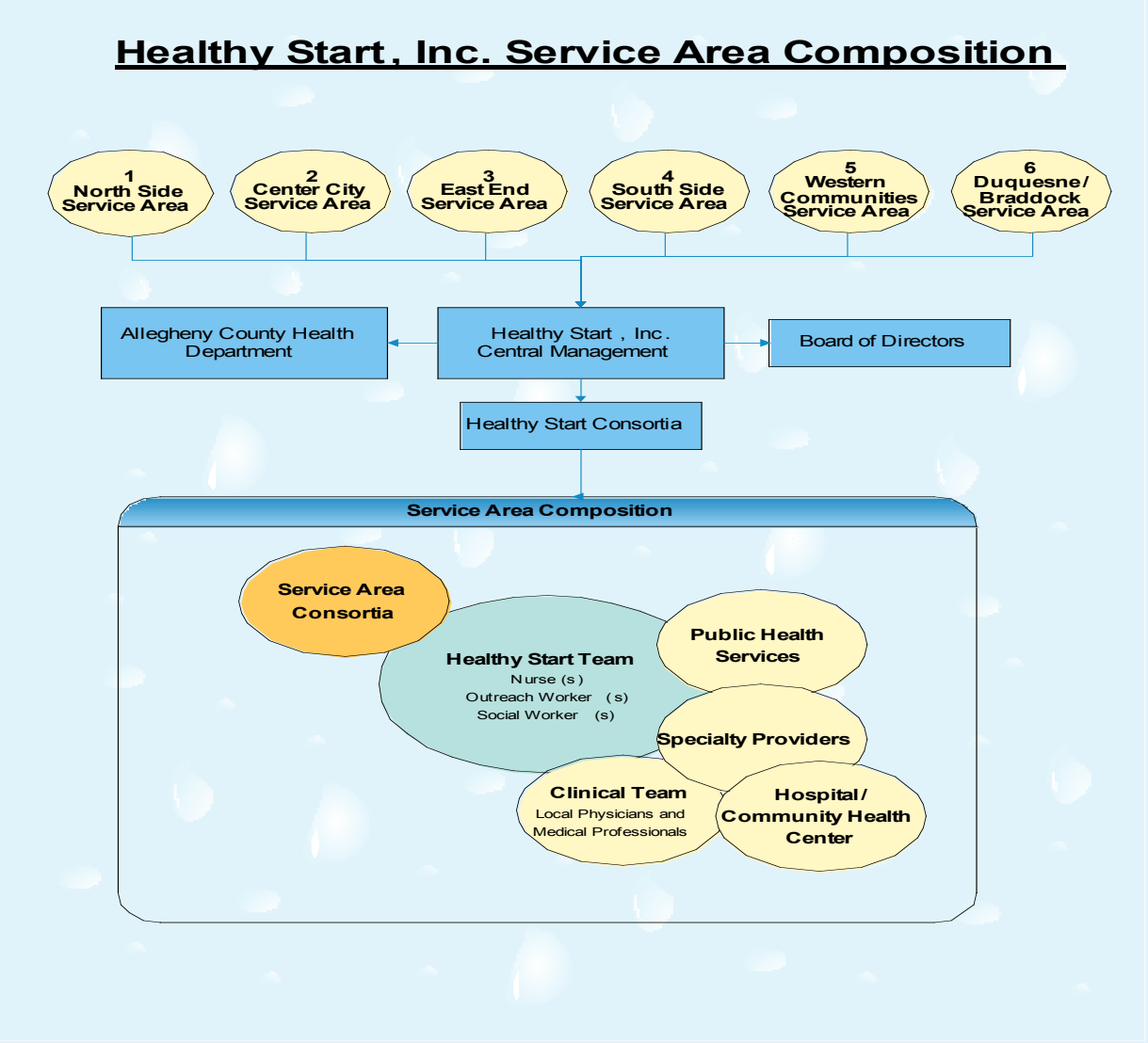
To effectively manage and assist these males, MIP provides a parallel model of case management utilizing home visiting and individualized care plans. Father-specific

resources (i.e. prisoner re-integration, male behavioral health, child support legal support) have been compiled and are available to the MIP team members.

Healthy Start Inc. has developed partnerships with a vast array of health and human service providers within the Pittsburgh/Allegheny County limits. The purpose of this extended network of organizations is to assure that each participant has access to not only specialized services, but ones located within their specific communities. The result is increased access to care through referral and monitoring provided by each member of the case management team.

Partnering Agencies	Purpose/Scope of Services	HS Target Area	Project Linkage and Communication
Resource Mothers Program	Serves pregnant and postpartum women and their infants; primarily targets pregnant women in 1st and 2nd trimester. (Caseload: 125 families)	Serves three non-target areas: McKeesport, Homestead N. Braddock	Program coordination and integration; Healthy Start has subcontract for case management services and support
Alliance for Infants (Early Intervention Service Coordination)	Serves high risk infants/children w/ developmental delays; birth – 3 years Caseload: 60-65 x 40 case managers	Allegheny County	Program integration -ACHD MCH nurses provide staffing support; Referrals and follow-up for HS case managed families
PA SIDS Alliance	Provides grief support for families who have experienced SIDS deaths Caseload: 520 per year	Allegheny County	Program coordination and integration; ACHD MCH refers all SIDS deaths to agency for investigation and support services; Referrals and follow-up for HS case managed families
Magee Women's Hospital Community Health Center	Pregnant women; postpartum women and their infants/children; limited home visits and follow-up Caseload: 2700 individuals yearly	Allegheny County	Medical health care referrals for uninsured and underinsured; reciprocal referrals for Healthy Start case management services
Allegheny County Human Services Office of Children, Youth and Family Services Contracted Programs/Agencies Spectrum, Holy Family Institute, Pressley Ridge, Auberle, Family Resources, (First Steps)	Case management home visits for infants/children at risk for neglect and abuse; adoption services; limited – long term involvement with families Caseload: 356 monthly	Allegheny County	Care coordination, i.e. case conferences; Referral services for parenting education and family support
Fathers Collaborative	Fathers with children 0 & up; case management; legal education, consultation,	Allegheny County	Program coordination and integration; Healthy Start is a collaborative member providing

Partnering Agencies	Purpose/Scope of Services	HS Target Area	Project Linkage and Communication
	mediation/litigation; parenting training/information; access/visitation planning/volunteer parent visitation plans and fatherhood training. Caseload: 400 yearly		program planning, referrals, group service and case management support as needed.

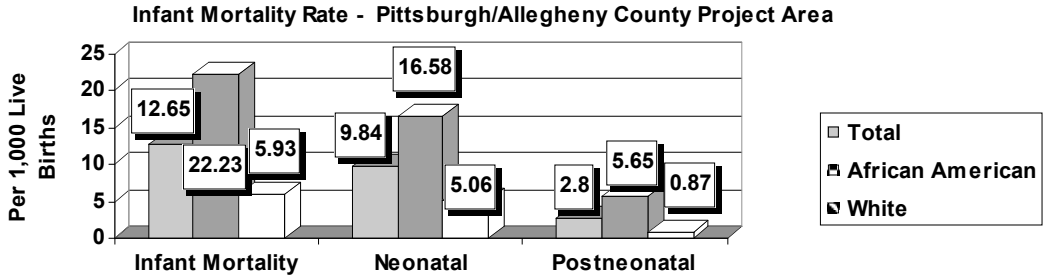


C.

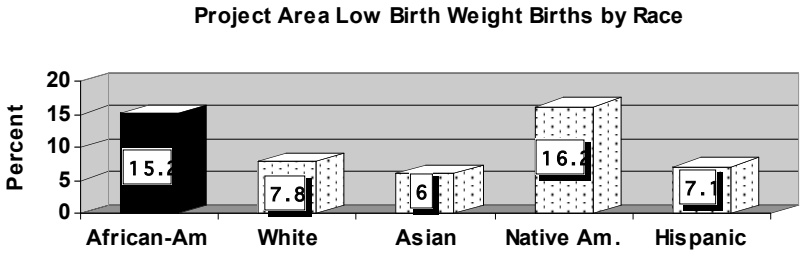
Participant barriers identified include lack of knowledge of the service system, skepticism about the effectiveness of prevention, inadequate or inappropriate utilization of health care services, and socioeconomic status. These factors are particularly pressing when dealing with mental health dilemmas including Postpartum Depression (PPD), Major Depression, and those dually diagnosed with a mental health disorder and substance

abuse. The convergence of the poor socioeconomic conditions and the high-risk population that make up the Healthy Start Project area create an environment where poor perinatal outcomes flourish. Many families express concerns about their experiences and with how they have been or are treated by health and human service professionals because of race or because of their economic status. The result is overwhelming reluctance to seeking services until health problems become a crisis and positive outcomes much less likely.

Please consider the following service area statistics during the report years: For the three-year
period (2000-2002), the Project Area accounted for one-half (49.9%) of all infant deaths in
Allegheny County. The Project area accounted for over three-fourths (75.78%) of all African-American infant deaths in Allegheny County. Further, of the births to African-American women,
15.2% were low birth weight, twice of White women (7.8%), which is disproportionate.



Note: There were no reported infant deaths for other racial/ethnic categories.
Source: PA State Health Department, Vital Statistics 2000-2002



Total Births n = 13,199, African-Am n = 5,487, White n = 6,914, Asian n = 496, Native Am. n = 37, Hispanic n = 198
Source: PA State Health Department, Vital Statistics 2000-2002

Consider that African-American women living in the Project Area were less likely to seek early prenatal care than White women. During 2000-2002, only 81.6% of African-American women received care in the first trimester of pregnancy compared to 91.8% for Whites. African-American women fall short of the Healthy People 2010 objective of 90%.

A major barrier for providers is the "office-based" approach to treatment and education. Many offer services at a central location and are unable or unwilling to travel to the homes or communities of those disparate persons in the most need of service. For Healthy Start participants, making basic travel arrangements is a challenge. Provider barriers also include lack of culturally competent and diverse staff. A lack of available follow-up for individuals and families in addressing health care needs, deficiency in knowledge of and linkage to community-based health and human services supports leave participants without consistency of care. Healthy Start is able to fulfill these voids by utilizing new and existent community partnerships with health care providers and expanding the knowledge base of our staff.

System barriers include fragmentation of health and human services, lack of coverage or inadequate reimbursement for services, lack of feasible and affordable transportation, and inadequate health and human enabling resources within a community. The multitude of programs has different application processes and eligibility requirements and being pregnant or having children often times deems a participant ineligible. For fathers, many of whom are unemployed and seeking steady work, obtaining employment is especially difficult due to past criminal records or very low educational status. Several of the target communities have insufficient numbers of obstetricians, pediatricians, behavioral/mental health, and employment training service providers with more services dwindling rather than expanding. The managed care system of compartmentalization of physical health, i.e. preventative medical care, and behavioral health services, i.e. mental health and substance abuse counseling and/or treatment, has served as a barrier to coordinating and integrating services for participants.

Health Education and Training

A.

From community forums-which drew more than 200 individuals and community representatives to all-day sessions, attendees identified the reasons why babies die and explored ways that potentially would reduce the risks-emerged several strong convictions:

- Babies would continue to die until everyone affirmed that every life had value
- Indigenous paraprofessional workers must be hired as Team members
- Health education, staff development and training would be mandatory program components

Classes were developed for three distinct audiences:

- Health professionals
- Paraprofessional and Healthy Start staff
- Community residents, including but not limited to Healthy Start case managed participants

Community members proposed that Multidisciplinary Team members, assigned to each Healthy Start Service Area, be equipped with a comprehensive "menu" of health information. In addition, they stressed the need for classes/workshops that developed oral and written communication skills and they emphasized that materials, designed for

the community, be culturally appropriate and at a 4th grade reading level. Topics introduced were smoking cessation, infant mortality, prenatal care instruction, parenting, STD's/HIV education, immunizations, preterm labor, incidence of low and very low birth weight births, family planning, alcohol used during pregnancy and healthy nutritional practices.

B.
Throughout the lifetime of the project, the Pittsburgh/Allegheny County Healthy Start program has remained committed to disseminate information in formation with our goal of improving the targeted communities knowledge, attitudes, behaviors and practices regarding sound perinatal and infant health.

Comprehensive, skilled-based, culturally appropriate, and multi-dimensional training efforts were aimed at educating the Healthy Start Multidisciplinary Teams, health and human service providers, the public, consumers, participants and physicians regarding cultural competence and cultural sensitivity, perinatal and postpartum care, health disparities and other risk factors such as prematurity and low-birthweight babies, smoking cessation, family planning/birth spacing, syphilis and the prevention and early identification of HIV/STDs, mental health, Sudden Infant Death Syndrome, sexual abuse and domestic violence.
The Training and Development Manager and the Multidisciplinary Teams, (consisting of registered nurses, outreach workers, the Male Initiative and social workers), used the ecological system model that identified need and presented culturally appropriate health education and trainings on identified topics.

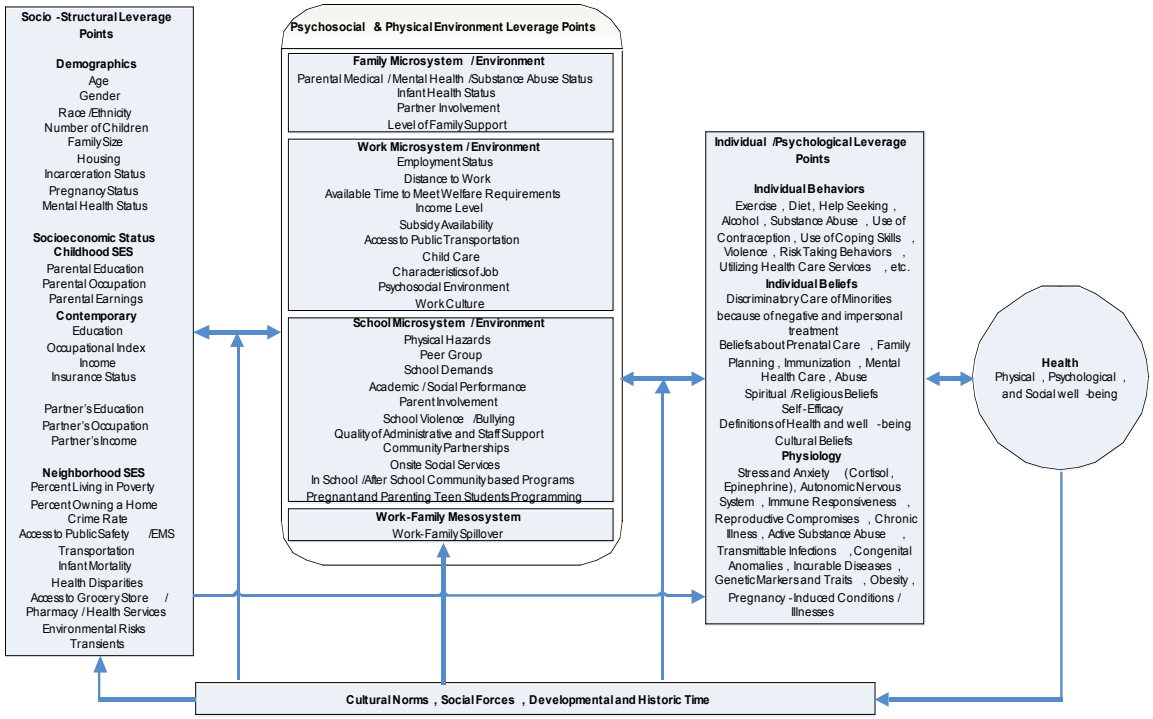
For the majority of the project period, the Training and Development Manager was supervised by the Executive Director. The Manager was responsible for identifying and scheduling in-service trainings, seminars and conferences for all Healthy Start, Inc. staff, volunteers, community residents, consumers and case managed participants. The Program Administrator and supervisors provided the necessary supervision to their staff to ensure that they are attending the trainings enabling them to provide the essential education and resources to their participants.

In our on-going effort to ensure in-depth health education and training, Healthy Start continued to employ the knowledge of various health educators throughout Ohio, Pennsylvania and West Virginia. This allows for an unbiased perspective, fresh ideas and new insights.

Trainings are designed and tailored to meet the participants, staff, consortium members and local health and human service providers at basic and advanced levels, and to assess risk factors that are linked to infant mortality and adverse birth outcomes. Pittsburgh and Allegheny County offer a unique blend of cultural diversity with each community exhibiting different risks and needs. Healthy Start's consortia ensures as the eyes and ears of each community that these areas are identified and appropriate trainings developed and delivered to the particular regional communities. Whenever possible, local health and

human service providers become partners in training to assure that the full support system in place for each community is sensitive and skilled in the delivery of services.

Pittsburgh Allegheny County Healthy Start Social Ecological Model of Health



Adapted from : Ovid : Grzywacz : Behavioral Med , Volume 26(3).Fall 2000.101-115, The Social Ecology of Health : Leverage Points and Linkages

C.

The following chart provides a comprehensive outline of the resources and events Healthy Start has utilized over the grant period to ensure successful outcomes. Included in the charts are identified needs and barriers to having an impact on projected outcomes associated with eliminating health disparities, reducing infant mortality rates and low weight births and ensuring overall positive perinatal outcomes.

A barrier to service delivery has been the static funding reserves. Healthy Start has remained committed, however, to maintaining and even expanding services to the community. Experience proves that a multi-systemic approach is more successful over time in improving the health and well-being of our targeted population. Therefore, Healthy Start has been challenged to become more creative and innovative in accessing and utilizing available resources to meet desired objectives. The charts below provide an overview perspective of our efforts.

Healthy Start, Inc. In-Service Trainings for 2001-2004

Training	Year				Collaborative Agencies	Credits	Hours	Number Attended				
	2001	2002	2003	2004				2001	2002	2003	2004	Total
Behavioral Health (Perinatal Depression, Behavioral Therapy)	[illegible]	[illegible]	[illegible]	[illegible]	Western Psychiatric Institute & Clinic(WPIC), HSI LSW, Community Mental Health Centers, Private Therapists	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	65
Interconception (Nutrition, Dental Hygiene, Family Planning /Contraception, Immunizations, Child Development & Safety	X(5)	[illegible]	X(4)	X	WIC, Allegheny County Health Department, Alliance for Infants and Toddlers, Office of Child Development, Family Health Council, Planned Parenthood of Western PA, Caring Foundation, Private Dental Providers, Specialist, Primary Care Providers		51	186	187	185	235	793
Domestic Violence & Sexual Abuse	X	X	X	X	Women's Center & Shelter, Pittsburgh Action Against Rape		6	34	41	46	34	155
Sexually Transmitted Infections/ HIV/AIDS	X(2)	X(7)	X(6)	X(7)	PA Mid-Atlantic Training Center, Allegheny County Health Department, Center for Minority Health, Pittsburgh Aids task Force, Pittsburgh AIDS Center for Treatment, University of Pittsburgh Graduate School of Public Health	yes	[illegible]	[illegible]	[illegible]	156	210	533
Neonatal Death & SIDS	X (2)	X(2)	X(2)	X(2)	Magee Women's Hospital, SIDS Alliance of PA		19	52	107	71	82	312
Medicaid, Temporary Aid for Needed Families & the Health System	X	X(2)	X	X	ACHD, Consultants, Department of Public Welfare		10	8	51	27	33	119
Pregnancy/Parenting Teen Pregnancy & Fatherhood	X(4)	X(3)	X(3)	X(4)	Family Health Council, Planned Parenthood of Western PA, Fatherhood Collaborative		30	120	116	129	119	484
Preterm Labor	X	X	X	X	University of Pittsburgh School of Nursing, Family Health Council, Inc., ACHD	yes	12	21	35	36	36	128
Staff Development (Cultural Competency, Confidentiality, CPR, Technical training, HRSA Webcast, Infection Control)	X(5)	X(3)	X(6)	X(11)	University of Pittsburgh, Healthy Start Counsel, PA Department of Health, Wright State University, Allegheny County Health Department, American Red Cross, HRSA	yes	78	149	205	157	250	761
Smoking Cessation	X	X	X	X(2)	Healthy Hearts & Souls, American Lung Association, PA Area Health Education Center (AHEC), American Cancer Society, Tobacco Free Allegheny County, March of Dimes, Pa Department of Welfare,		14	10	22	50	49	131
LSW Required Certification Trainings		X	X	X	University of Pittsburgh School of Social Work, Pittsburgh Pastoral Institute	yes	42			21	21	42
Student Nurse Training	X	X	X	X	University of Pittsburgh School of Nursing		191	5	7	4	4	20
Substance Abuse	X	X	X	X	Family Links, Allegheny County Office of Children, Youth & Families, Gateway Rehabilitation Center	yes	10	44	40	23	19	126

Program Participant Health Education Table

Topic	Methods	Provider	Healthy People 2010
Smoking 25-35% of participants indicate they are smokers.	-Group (2 family focus nights, 6 baby showers, 3 life skills groups, 2 regional-based presentations) -One-on-One (12 outreach worker home visits, 6 RN home visits, 6 case conferences per participant, telephone vignettes, Clean Air for Healthy Children) -Written Materials (Brochures, pamphlets, fact sheets, purple health diary) -Referral to collaborating providers	-HSI, Healthy Hearts & Souls -HSI Helpline, Healthy Hearts & Souls -Allegheny County Health Department, Tobacco Free Allegheny -Healthy Hearts & Souls, STOP Program, American Cancer Society, Tobacco Free -Allegheny, March of Dimes, PA Dept. of Welfare	3.2 16.17 27.1, 27.2, 27.10
Depression/Mental Health -100% will be screened and referrals made as indicated.	-Group (1 Family focus nights, 3 life skills groups, 4 regional-based focus groups, bi-monthly support groups) -One-on-One (RN's, outreach workers, social workers) -Written Materials (Pamphlets, brochures, fact sheets) -Referral to collaborating providers (offered)	-HSI, Western Psychiatric Institute and Clinic (WPIC) at the Univ. of Pittsburgh -HSI, Helpline -HSI, WPIC, Nat'l Institute. of Health, Nat'l Institute. of Mental Health, Pa Perinatal Partnership -WPIC, Community Mental Health Centers, Private Therapists, managed care-Community Care Behavioral Health	18.1, 18.2, 18.6, 18.9, 18.10
HIV/STD's with a focus on Syphilis (highest rising STD) -100% will receive education.	-Group (2 Family focus nights, 6 baby showers, 3 life skills groups, yearly symposium, 2 regional-based presentations) -One-on-One (During each enrollment, delivered as needed at each outreach worker and RN home visit) -Written Materials (Brochures, fact sheets, pamphlets, flyers, condom distribution, purple health diary) -Referral to collaborating providers (Enrollment, Helpline, home visits, HSI sponsored events)	-HSI, PA Mid-Atlantic AIDS Education Training Center -HSI, ACHD, PA MidAtlantic -Center for Minority Health/Graduate School of Public Health, Pittsburgh AIDS Taskforce, -Minority AIDS Work Group, Magee Women's Hospital, Children's Hospital Pittsburgh, -Allegheny County Health Department, Primary Care Health Services, Inc.	25.3, 25.8, 25.9, 25.10
Family Planning -20-35% of program participants indicate having an STD, annually	-Group (Family focus nights, 3 life skills groups, 6 baby showers, 6 regional focus groups) -One-on-One (RN's, outreach workers, social workers) -Written Materials (Pamphlets, brochures, fact sheets) -Referral to collaborating providers	-HSI, Family Health Council, HSI Teen Outreach Specialist -HSI, Helpline -HSI, Allegheny, Family Health Council, Planned Parenthood of Western Pa. -Family Health Council, Planned Parenthood of W. Pa., Primary Care physicians, specialists	9.1, 9.2, 9.3, 9.6, 9.7, 9.10, 9.11
Cultural Competency -100% will receive education.	-Group (Cultural Sensitivity and Competence Symposium, Family Focus Nights, Life Skills Groups) -One-on-One (RN's, outreach workers) Written Materials (Pamphlets, brochures, fact sheets) Referral to collaborating providers	-HSI, Univ. of Pittsburgh WPIC and OCD, ACHD, Federally Qualified Health Centers, Board and Consortia Professional representatives -HSI -HSI -HSI, OCD	11.6
Preterm Labor -35-50% of program participants will indicate having signs and symptoms of preterm labor	-Group (2 Family focus nights, 6 baby showers, 3 life skills groups, yearly symposium, 2 regional-based presentations) -One-on-One (During each enrollment, delivered at every prenatal home visit by outreach worker and RN) -Written Materials (Brochures, pamphlets, fact sheets, purple health diary) -Referral to collaborating providers (Enrollment, Helpline, home visits, HSI sponsored events)	-Magee Women's Hospital -HSI LSW, OCD, Federally Qualified Health Centers, Family Support -HSI, Allegheny County Health Department -Magee Women's Hospital, Private Physicians, Community Health Centers, March of Dimes -Center for Minority Health	16.10, 16.11
Information on back to sleep/safe sleep for infants and toddlers -Projected total of participants receiving education is 100%	-Group (2 Family focus nights, 6 baby showers, 3 life skills groups, yearly symposium, 2 regional-based presentations) -One-on-One (During each enrollment, delivered at every prenatal home visit by outreach worker and RN) -Written Materials (Back to sleep brochures, SIDS brochures, letter of condolence, grief/loss counseling materials) -Referral to collaborating providers (Grief and loss)	-HSI, SIDS Alliance, African American Women's AKA's (Sorority), -HSI -Consumer Safety Commission, SIDS Alliance, Children's Hospital -HSI LSW, Magee Women's Hospital, National SIDS Hotline, Caring Place, Compassionate Friends, The Good Grief Center,	16.1, 16.13
Substance Abuse Prevention -30-40% of program participants indicate abusing alcohol and other drugs	-Group (2 Family focus nights, 6 baby showers, 3 life skills groups, yearly symposium, 2 regional-based presentations) -One-on-One (During each enrollment, delivered at every prenatal home visit by outreach worker and RN) -Written Materials (Brochures, pamphlets, fact sheets) -Referral to collaborating providers	-HSI,PA Mid-Atlantic AIDS Education Training Center, Community Care Behavioral Health Organization, Family Links, HSI -Allegheny County Health Department, American Cancer Society, Department of Health and Human Services, Drug and Alcohol Resistance Education (D.A.R.E.) -HSI CAC, -Gateway Rehabilitation Center, Zoar New Day, Sojourner, Operation Nehemiah, Addison Terrace Learning Center, Perinatal Addiction Center, House of the Crossroads, POWER, Pyramid, F.A.C.E, Mothers and Sons, Lydia's Place, Renewal Incorporated	16.17, 16.18
Domestic Violence -8-12% report incidents of domestic violence annually.	-Group (2 Family focus nights, 6 life skills groups, 4 regional-based presentations) -One-on-One (At a minimum of two home visits a year, During each enrollment, delivered by outreach worker and RN) -Written Materials (Pamphlets, brochures, fact sheets only provided upon request, group settings) -Referral to collaborating providers	-HSI, Women's Center and Shelter, -HSI, HSI LSW -HSI, National Domestic Violence Association -Pittsburgh and Allegheny County Police Department, Pittsburgh Action Against Rape (P.A.A.R.), Women's Place, Domestic Abuse Counseling (DAC), Victims of Violence and Crime	15.34, 15.37

Staff and Consortia Health Education Training			
Training Topic	**Provider/Resource**	**Rationale**	**Training Hrs/Yr**
Postpartum Depression and Dialectic Behavioral Therapy (DBT) Healthy People 2010 Objectives 18.1, 18.2, 18.9, 18.10	Western Psychiatric Institute and Clinic (WPIC)/ Local Provider	Provide staff and consortia with the specific techniques for the provision of services directly related to the symptoms of Postpartum Depression.	Minimum 1.5
Preterm Labor Healthy People 2010 Objectives 16.10, 16.11	Allegheny County Health Department/ Local Title V Provider	Increase the skills of the staff and consortia to educate the community on the signs and symptoms of preterm labor and utilize intervention strategies.	Minimum 1.5
Substance Abuse Prevention Healthy People 2010 Objectives 16.17, 16.18	HSI,PA Mid-Atlantic AIDS Education Training Center, Community Care Behavioral Health Organization, Family Links, HSI	Increase the ability of staff and consortia to recognize the signs and symptoms of substance use and offer guidance to program and community participants in accessing treatment and counseling services to increase the incidence of positive perinatal outcomes.	Minimum 1.5
Safe Sleep/Back to Sleep and Sudden Infant Death Syndrome (SIDS) Healthy People 2010 Objectives 16.1, 16.13	The Pennsylvania SIDS Alliance/ State-Wide Network	Awareness of medically supported sleeping practices, risk factors, and preventative measures.	Minimum 1.5

HIV/AIDS, Sexually Transmitted Infections, especially Syphilis Healthy People 2010 Objectives 25.3, 25.8, 25.9, 25.10	The Pennsylvania MidAtlantic AIDS Education Training Center/ Regional Training Center	Increase awareness regarding intervention (accessing medical care) and prevention (contraception and family planning) as related to mothers, fathers, and baby.	Minimum 1.5
Cultural Competency Healthy People 2010 Objectives 11.6	The Pennsylvania MidAtlantic AIDS Education Training Center/Regional Training Center	Increase awareness of cultural biases and improve the number of participants willing to utilize the available enabling services within and outside of their community.	Minimum 1.5
Family Planning/ Birth Spacing Healthy People 2010 Objectives 9.1, 9.2, 9.3, 9.6, 9.7, 9.10, 9.11	Family Health Council/ Title X Family Planning Provider	Increase knowledge of contraception methods and access of medical services. Increase awareness of the maternal/infant risk factors of having another child within two years of last birth.	Minimum 1.5
Smoking Cessation Healthy People 2010 Objectives 3.2, 16.17, 27.1, 27.2, 27.10	Pennsylvania Area Health Education Center (AHEC)/ Local Provider	Increase awareness of effective strategies to reduce or quit smoking and educating program and community on the health benefits of smoking cessation.	Minimum 3

Community Participant Health Education: General Population and Local Providers				
Training Topic	**Provider/Resource**	**Target Audience**	**Rationale**	**Health Education Activities Years 1-4**
Substance Abuse Prevention Healthy People 2010 Objectives 16.17, 16.18	HSI,PA Mid-Atlantic AIDS Education Training Center, Community Care Behavioral Health Organization, Family Links, HSI	Pregnant and Parenting Women and Men Local Health Care and Drug and Alcohol Providers	Promote awareness of the effects of substance use on pregnancy and development. Increase ability to provide direction in accessing treatment. Improve the ability of providers to understand the causes for substance use related to poverty and provide appropriate services.	Health Fairs, Consortia Presentations, Helpline, Community Canvassing of Community Care Providers
Breastfeeding and Infant Nutrition Healthy People 2010 Objectives 16.19, 19.4	Healthy Start, Inc., Women, Infants and Children Nutrition Program (WIC)/ Allegheny County WIC Provider, Allegheny County Health Department, All County and City Obstetrical Units	Pregnant and Parenting Women Local Health Care Providers	Promote appropriate and effective breastfeeding and infant nutrition practices. Provide assistance and support to mothers having difficulties with breastfeeding. Increase the number and percentage of women who breastfeed. Reduce the cultural disparities associated with breastfeeding among low income and minority populations. Provide information and referral sources	Health Fairs, Consortia Presentations, Breastfeeding Helpline, National Breastfeeding Awareness Campaign, Baby Showers, Community Canvassing of Community Care Providers
Perinatal and Postpartum Depression Healthy People 2010 Objectives 18.1, 18.2, 18.9, 18.10	Healthy Start, Inc. and Western Psychiatric Institute and Clinic (WPIC)/ Local Provider	Pregnant and Parenting Women, Male Caregivers Local Health Care Providers: Community Health Centers	Increase awareness on the signs and symptoms of depression. Increase awareness of how to obtain necessary treatment. Reduce the cultural disparities associated with accessing mental health treatment among low income and minority populations. Provide information and referral sources	Health Fairs, Baby Showers, National Depression Screening Month/ Day Activity, Helpline, Community Canvassing of Community Care Providers
Preterm Labor Healthy People 2010 Objectives 16.10, 16.11	Healthy Start, Inc., and Allegheny County Health Department/ Local Title V Provider	Pregnant and Parenting Women, Fathers or Male Partners, Professionals Local Health Care Providers: Community Health Centers	Increase awareness on the signs and symptoms of Preterm Labor and provide appropriate intervention strategies. Increase the number and percent of women who contact their medical provider and receive care for Preterm Labor in a timely manner. Provide information and referral sources	Health Fairs, Consortia Presentations, Baby Showers , HSI Telephone Vignette (Recorded Health Education Messages), Helpline, Community Canvassing of Community Care Providers
Immunizations Healthy People 2010 Objectives 14.1, 14.2, 14.22, 14.23, 14.24, 14.27	Healthy Start, Inc. and Allegheny County Health Department/ Local Title V Provider, Primary Care Physicians, Community Health Centers	Pregnant and Parenting Women/Adolescents, Fathers, Partners and Male Caregivers, Grandparents, Foster Parents, Professionals Local Health Care Providers:	Increase the number and percentage of infant/young toddlers who are up-to-date on recommended childhood immunizations. Increase the number and percent of parents who attend the scheduled well-baby medical appointments. Provide information and referral sources	Health Fairs, Consortia Presentations, Baby Showers, HSI Telephone Vignette (Recorded Health Education Messages), Helpline, Community Canvassing of Community Care Providers
Safe Sleep/Back to Sleep and Sudden Infant Death Syndrome (SIDS) Healthy People 2010 Objectives 16.1, 16.13	Healthy Start, Inc., The Pennsylvania SIDS Alliance/ State-Wide Network, Magee Women's Hospital, The University of Pittsburgh Center for Minority Health and Graduate School of Public Health, Allegheny County Health Department, American Academy of Pediatrics	Pregnant and Parenting Women/Adolescents, Fathers, Partners and Male Caregivers, Grandparents, Foster Parents, Professionals Local Health Care Providers: Community Health Centers, Family Support Centers, Private Physicians, Child Care Providers	Increase the awareness and use of safe sleeping practices for newborns and infants up to one year of age. Provide information and referral sources for access to infant sleeping items (cribs, mattresses, etc.)	Health Fairs, Consortia Presentations, Baby Showers, HSI Telephone Vignette (Recorded Health Education Messages), Helpline, Community Canvassing of Community Care Providers

HIV/AIDS, Sexually Transmitted Infections, especially Syphilis Healthy People 2010 Objectives 25.3, 25.8, 25.9, 25.10	Healthy Start, Inc., The Pennsylvania MidAtlantic AIDS Education Training Center/ Regional Training Center, The Allegheny County Health Department, Family Health Council/ Local Title X Provider, Community Health Centers	Pregnant and Parenting Women/Adolescents, Fathers, Partners and Male Caregivers, Grandparents, Foster Parents, Professionals Local Health Care Providers: Community Health Centers, Family Support Centers, Private Physicians	Increase awareness regarding intervention (accessing medical care) and prevention (contraception and family planning) as related to mothers, fathers, and baby. Decrease incidence of infant infection. Decrease incidence of infant birth defects and other congenital anomalies. Provide information and referral sources	Health Fairs, HSI Telephone Vignette (Recorded Health Education Messages), Helpline, Community Canvassing of Community Care Providers
Smoking Cessation Healthy People 2010 Objectives 3.2, 16.17, 27.1, 27.2, 27.10	Healthy Start, Inc., Healthy Hearts and Souls, American Lung Association, Allegheny County Health Department, Pennsylvania Area Health Education Center (AHEC)/ Local Provider	Pregnant and Parenting Women/Adolescents, Fathers, Partners and Male Caregivers, Grandparents, Foster Parents, Professionals Local Health Care Providers: Community Health Centers, Family Support Centers, Private Physicians	Increase awareness of effective strategies to reduce or quit smoking and educating program and community on the health benefits of smoking cessation. Information and referral for resources.	Health Fairs Baby Showers, Consortia Presentations, Baby Showers, HSI Telephone Vignette (Recorded Health Education Messages), Helpline, National Awareness Campaigns, Promotion Activities with Health Hearts and Souls and the American Lung Association, Community Canvassing of Community Care
Cultural Competency and Sensitivity Healthy People 2010 Objectives 11.6	Healthy Start, Inc.	Pregnant and Parenting Women and Men University of Pittsburgh's Graduate School of Public Health, Center for Minority Health, School of Social Work, School of Nursing and Office of Child Development, Western Psychiatric Institute and Clinic, Primary Care Health Services	Increase awareness of cultural barriers to access of care for low income and minority populations. Enable staff to work effectively across cultures.	Yearly Symposium, Community Canvassing of Community Care Providers

Interconceptional Care

A.
Pittsburgh/Allegheny County Healthy Start project has recognized the need for interconceptional services of women and their infants since its inception.

The original Healthy Start grant application written in 1990 contained a comprehensive strategy for attaining family planning, prenatal, obstetrical, pediatric and postpartum healthcare services for woman of childbearing age (10-44) and their infants/toddlers, and the community. Healthy Start services were provided through the coordination of existing services that included a case management system of employing indigenous support staff, OW, nurses, SW and field managers which enhanced continued one to one relationships.

Healthy Start describes interconceptional care as the period from delivery through a baby's second birthday. However, Healthy Start, Inc. recognizes that our program participant education on interconceptional topics such as family planning and birth spacing need to begin during pregnancy. During the interconceptional period, home visiting activities services, and interconceptional education vary considerably based on the woman's stage of gestation when entering the program, their base of knowledge, and their motivation and ability to assimilate the provided material. The typical interconceptional woman was approximately 23 years old, was African American, never married, enrolled in Medicaid and is unemployed, and she may have had a past experience with a poor pregnancy outcome. During the project period, we served 1,075 interconceptional women and 1,723 infants 0-24 months during the reporting period.

Living in Allegheny County/Pittsburgh metropolitan area, women have access to renowned medical institutions. However many of these women experience problematic navigation of the health and human service system and disparate socioeconomic factors such as the cycle of poverty, poor/inadequate housing and education, poor lifestyle and behavioral habits such as smoking and substance abuse, mental health conditions, poor birth spacing, domestic abuse and lack of familial support, impacting and contributing to poor interconceptional health. These women may also not access the healthcare system because of negative/impersonal ways they have been previously treated because of race or socioeconomic status.

Healthy Start, Inc. aims to motivate young women and their male counterparts to assume responsibility for their own health and the health and wellbeing of their infants while providing the means for increasing accessibility and acceptability of existing services that will help achieve those ends. Our partnerships with Federally Qualified Health Centers, Allegheny County Health Department, Department of Public Welfare, WIC, and local Primary Care providers and area hospitals are key in helping us achieve these goals.

B.
Direct Service staff, nurses, social worker and specifically trained outreach workers, employees of Healthy Start, Inc., conduct interconceptional services for high-risk pregnant and postpartum women and their infants.

Having a six-week postpartum check-up is very important for interconceptional health care. The visit gives the doctor a chance to make sure that the mother is recovering well, physically and emotionally. It also gives the mother an opportunity to have her questions answered and her concerns addressed.

During the interconceptional period, Healthy Start tracked whether a woman had her postpartum check-up within six weeks of delivery.

If the postpartum appointment had not been scheduled; Core Team staff initiated a series of activities. The activities were as follows:

- During the first home visit, the program participant and outreach worker/nurse called the doctor's office and scheduled an appointment.
- The staff documented the appointment date on the HSI Postpartum Visit Record Form and the Format for Case Review. The appointment date was presented during Case Review, and the Form is placed in the tickler system, which is a system built to provide reminders and prompt activities related to programmatic operations of Healthy Start.
- At subsequent home visits, Core Team staff reminded the program participant of her upcoming appointment.
- Ten days before the scheduled appointment, the Core Team Program Assistant (PA) sent a reminder post card via U.S. Mail via the use of the tickler system.
- Lastly, the Program Assistant (PA) placed a reminder telephone call one day before the scheduled appointment.

This Healthy Start program ascertained whether a woman had chosen a family planning option during the initial assessment and during the enrollment visit. Family planning and birth control options were again addressed at home visits in the second and third trimesters, and at the infant's first, second, and third home visits and on subsequent visits as needed. Healthy Start case managers followed up with a typical interconceptional participant at least seven times regarding her use of family planning.

Members of Pittsburgh's Multidisciplinary Teams ascertained whether a woman had chosen a family planning option at the initial assessment and at the enrollment visit. The Pittsburgh/Allegheny County Healthy Start program followed up and addressed birth control/family planning at home visits in the second (2^{nd}) and third (3^{rd}) trimester and at the infants' first (1^{st}), second (2^{nd}) and third (3^{rd}) home visit and on subsequent visits as needed.

The following criteria are established for high risk assessment and ongoing case management through the baby's second birthday.

The typical high risk infant/toddler usually was defined by, but not limited to: low birth weight/very low birth weight/preterm births; developmental delays; medical conditions (congenital anomalies, gastric reflux, failure to thrive, mother's failure to follow-up medically, multiple acute infections, i.e., ear infections, asthma); infants born with positive toxicological screens; or mother's use of alcohol and/or other drugs.

The typical high risk mother was characterized by : active use of alcohol and/or other drugs; smoking; mental health/ mental retardation diagnosis; prior preterm birth; repeat pregnancy (within a 24 month period); pregnancy terminations (3 or more miscarriage/spontaneous abortions, loss history); domestic violence; medical conditions (insulin dependent, diabetes/gestational diabetes, hypertension, abnormal pap, HIV/AIDS), teens (17 years and younger); mothers greater than or equal to 35 years old; and multiple gestation (twins, triplets, etc.).

Based on risks and needs, our case managers provided appropriate education and referrals to enabling services to best help program participants overcome social, medical, and cultural obstacles. Assessed from day one at intake and throughout their case management enrollment period, outreach workers, nurses, and social workers were equipped to identify and refer our participants for services within the differing communities. Healthy Start Inc. maintains partnerships with community service providers in the areas of Early Intervention, Neonatal Intensive Care and Transitional Infant Care Centers, Parenting Education, SIDS, and Community Health Centers to assure that those interconceptional programs and community participants receive the treatment warranted. For all other enabling services, referrals were conducted based on need and any barriers to receiving services were worked out between the participant, their family, and case management staff. Healthy Start Inc. has established protocols to assure that referrals for these enabling services are verified and that services are rendered.

The typical high risk father or male caregiver is characterized by: active substance abuse; mental health/ mental retardation diagnosis; domestic violence; medical risk (insulin dependent diabetes, high blood pressure, HIV/AIDS), teens (17 years and younger); paroled or on probation for a serious criminal offense.

Healthy Start tracked whether an infant had a newborn visit from a Healthy Start nurse within four weeks of hospital discharge by first having a Release of Information and Authorization signed at the initial enrollment of a participant. This allowed the staff to call the participant. Staff obtained the estimated date of confinement (EDC) and other pertinent information. The worker began educating the mother to call our office upon the birth of her baby. If the mother didn't call, staff placed a call to the participant, obtained the discharge information and documented the information in the participant's chart and in the Format for Case Review. The participant's information (dates to be contacted) was placed in the case management tickler system. The Tickler served as the vehicle to prompt a series of Core Team case management activities (home visits, reminder card and/or telephone calls). In addition, all visit dates were entered and maintained in the Healthy Start Management Information System (MIS).

This program ensured that the infant had a medical home for well child care by gathering information from the mother immediately after delivery. The information was documented on the Postpartum Record Form and the Format for Case Review. If the infant did not have a medical home, the Healthy Start outreach worker provided the mother with names of pediatricians. The medical home information was presented at case review and transferred into the Management Information System. During the project period 100% of infants enrolled had a medical home.

The immunization status is tracked by the field staff. When the baby was born the nurses and outreach workers began documenting in the participant's chart whether or not the infant received immunizations before leaving the hospital. If the baby's immunizations were not up-to-date, the participant received information on and education about age-appropriate immunizations. The staff took mother and baby to appointments, provided child care, activated the tickler system, followed up with home visits, and transferred information to the Management Information System.

Because the rate of postpartum depression (PPD) was high in the project area (30-45%), this Healthy Start program had a protocol for screening program participants for the disorder. The identification of mothers with PPD was extremely important because of the detrimental effects the illness can have on the mother, her baby, and the rest of her family. Mothers who screened positive for PPD were given referrals to mental health providers as soon as they would accept one. The staff monitored the mother throughout the interconceptional period whether she was in treatment or not, so as to determine risk to herself and others.

In accordance with existing Standards and Protocols, Healthy Start offered the following services to our interconceptional program participants.

- Home visits
- Telephone contacts
- Reminder Notices
- Education about perinatal issues
- Referrals to community health and human services
- Monitoring of mother and child

Specifically, HS program participants are assisted by HS Core Team staff to improve their diets, monitor their weight, and encourage and assist women to eliminate their use of cigarettes, alcohol and drugs.

Team Members taught pregnant women to identify the signs of pregnancy complications before they became serious. In addition, they encouraged regular rest, appropriate exercise, and personal hygiene related to obstetrical health, prepared for labor and delivery, prepared parents for early care of the newborn, encouraged appropriate use of the health care system; and encouraged families to make plans regarding subsequent pregnancies, returning to school, and finding employment. The nurses, social workers, and MIP outreach workers screened for depression and referred to treatment as needed.

During the interconceptional period, Healthy Start case managers provided services to infants and toddlers. The services provided by Healthy Start, Inc. included:

- Home Visits
- Risk Assessments
- Health Promotions
- Intervention Strategies

In Addition, staff

- Identified and eliminates barriers to care
- Provided transportation and childcare
- Educated on appropriate sleep position and SIDS
- Focused on newborn needs (feeding, changing and bathing)
- Observed baby's responses and styles
- Monitored infant growth and development (height, weight and head circumference)
- Ensured WIC enrollment and appropriate nutrition
- Oversaw well baby appointments, immunizations and health check-ups
- Advised on the importance of delaying solid food
- Discussed infant teething, dental care and dental services
- Introduced baby's capacity for positive and negative behaviors
- Utilized the Denver II Development and Ages and Stages
- Conducted child development assessments
- Measured personal-social, fine motor-adaptive, language and gross motor progress
- Referred to Early Intervention program
- Linked with other local programs that support children with special health care needs
- Promoted healthy behaviors
- Counseled on infant safety

During the two (2) years after delivery, Healthy Start Core Team staff contacted a typical interconceptional program participant a minimum of 14 times or according to their needs as identified in the Risk Assessments.

C.
Identified participant barriers included lack of knowledge and skepticism about the effectiveness of prevention, inadequate or inappropriate utilization of health care services and socioeconomic status. The convergence of poor socioeconomic conditions and the high-risk population make up the Healthy Start Inc. Numerous barriers existed between individuals/families and the care they needed. For example, the inability to pay for services caused many women to delay or even forgo prenatal care. Some also may not have realized the importance of prenatal or preventative pediatric care. A woman and her family may have been overwhelmed by the stresses of poverty. Concerns about feeding, clothing or even caring for the family, plus unemployment, crime and other issues can easily override the importance of basic preventative health care. Additionally, many families expressed concerns about how they have been treated due to their race, or because they relied on public assistance. Therefore, were reluctant to seek services until health problems became a crisis.

Healthcare Provider barriers included a lack of culturally competent and diverse staff, lack of training in patient prevention counseling, lack of follow-up for individuals and families in addressing health care needs, and lack of knowledge about and linkage to community-based health and human services. In addition, some providers' practices were seen as racially discriminatory by participants.

System barriers included fragmentation of health and human services, lack of coverage or inadequate reimbursement for services, lack of transportation, and inadequate health and human services resources within a community. The programs, which were available, had different application processes and eligibility requirements. Several of the Healthy Start target communities lacked sufficient numbers of obstetricians, pediatricians and/or behavioral health service providers. The managed care system of compartmentalization of physical healthcare, and behavioral healthcare services, had also served as a barrier to coordinating and integrating services for participants. Confidentiality issues, many related to the new privacy regulations under the Health Insurance Portability and Accountability Act of 1996, also served as a major barrier to coordination of care.

Healthy Start aimed to overcome these barriers of program participants We assessed participant financial eligibility, such as Medicaid or Title X eligibility, for receipt of health care services and we provided health education on the importance of having a medical home. Systems barriers were addressed by assisting with transportation by providing bus tickets and by providing transport via healthy start vehicles, assisting with child care and identifying available healthcare facilities as described above. Additionally systems barriers have also been addressed by establishing primary health care centers in underserved Healthy Start communities through creation of partnerships between the private health care providers. In addition, we intervened with healthcare providers when discriminatory issues arose by becoming advocates for the individuals and families involved. For example, we may accompanied participants on visits to health care providers or we followed-up on participants' concerns of biased treatment.

Depression Screening and Referral

A.
The rationale for implementing depression screening and referral at Healthy Start, Inc. (HSI) Pittsburgh was a result of the feedback from the community. They recognized that the participants were suffering from the stress and depression brought on by pregnancy, their socio-economic status, being underserved by the health care system, and a shortage of mental health care providers. Therefore, depression screening and referral of our program participants was implemented in order to identify those who might be in need of mental health services and also to help them access the services they need.

The approach used by this Healthy Start program to address perinatal depression is multi-faceted and multi-leveled. At the program participant level, the services of education about depression and depression screening and referral are delivered through home visiting and case management. The home visiting approach is used because the participants' circumstances make it nearly impossible for them to access services in the community. Inter-agency and HSI social worker referrals are made for those participants who are in need of mental health services and will accept them. These services are used to help break down the barriers that keep our participants from seeking the help they need.

At the Healthy Start staff level, education about depression and mental health providers is ongoing so that they are up-to-date on the latest information about the illness and about where to refer our participants for evaluations and treatment.

A newsletter is published by the staff to further educate the community about mental health as well as other health issues. Two goals of this newsletter are to break down the stigma associated with mental illness and to dispel myths about it by offering factual information. The newsletter is distributed free to our participants, staff, consortia, board members, community providers, members of the academic community, and elected representatives.

At the community level, Healthy Start strives to be a change agent. Workshops, seminars, and symposiums are held for the community stakeholders to continually educate them about mental illness, its effects on our population, and the obstacles they must overcome to receive care. This program actively looks for opportunities to collaborate with those who provide services as well as with those who do research and set policy. Our collaboration with the local universities' internship programs is an example of how this program heightens awareness of the problems faced by our population and trains people who can help ameliorate the situation.

B.
The components of the depression intervention listed in the following charts reflect the program's multi-leveled approach. The screening, referral and home visit services are direct services to the participants. Case review is a function of the staff. Having interns and the newsletter are ways in which this program educates the community. And the data collection enables the program to evaluate and report to the stakeholders at every level.

The rationale for having these various components is that our participants live in an environment that is not conducive to caring for their mental health. They are faced with barriers that are difficult to overcome such as lack of providers, the stigma of mental illness, inability to pay for services, insensitivity and discrimination of the providers, difficulty in getting to providers, and child care while attending appointments. Therefore, this Healthy Start program has been working as a change agent at those levels and in those areas which will effect positive change in the care of our participants. Screening all healthy start participants on a regular basis helps us monitor their mental health needs for the duration of their enrollment. Referrals are offered at the first signs and symptoms of depression to keep the illness from progressing and making treatment more difficult. At the same time, Healthy Start tries to educate the community providers about the circumstances and barriers facing our participants in an effort to make the systems working with our participants more accommodating and effective. By using a holistic approach this program continually works to improve maternal and child outcomes in the area of mental health.

Components	Resources needed to implement intervention	Changes and rationale
Depression Screening – RN's screened all enrolled program participants according to Healthy Start depression screening protocol	-RN's, licensed social worker (LSW), program assistants -Edinburgh Postnatal Depression Screen forms -depression screening flowchart (protocol) -computers	-RN's began universal screening of participants due to not having a social worker to screen participants on a referral basis. -Hired licensed social worker to manage the depression screening and referral component -Implemented depression screening flowchart in order to establish a protocol based on scores for screening participants, and for referring those who may need immediate attention due to mental health issues. -Enabled computer to send reminders for those participants whose 6-month screening is due.
Referrals - With participant consent, referrals were made to mental health providers for those participants who scored "9" or higher on the depression scale, or for those who requested one based on their own perceived need.	-RN's, LSW, outreach workers -Depression screen flowchart -Social Worker Referral forms -Interagency referral forms -Community mental health providers, hospitals, PCP's	
Data collection - Collect data (scores) from Edinburgh Postnatal Depression Scale and enter into depression database. Additional data collected with scores include names, date, region, assessor, medication, counseling, refused services (referral), and other comments.	-RN's, LSW -Edinburgh forms -computer systems	
Home Visits - Participants received home visits from LSW if they had been referred by the RN's or outreach workers. LSW conducted assessment interview. Depending on results of interview: LSW visited participant on a regular	LSW, participants, transportation, phone and internet access, referral forms, progress notes, referral resources	

basis for the short term and then referred, or referred participant after researching providers and follow-up with phone call.		
Case review - LSW attended case review to consult with the case management team of those participants requesting or receiving LSW visits.	Case management team, LSW, progress notes, meeting room	
Internships - Program has had a relationship with University of Pittsburgh School of Social Work's Field Placement Office from which students are referred to Healthy Start in order to carry out their internships in bachelor's and master's level social work programs.	Healthy Start staff, intern, university, field learning plan, participants, field liaison from university	
Newsletter – 1500 newsletters have been distributed to staff, participants, Board of Directors, Consortia, community providers, and elected officials for the purpose of informing these stakeholders on issues of maternal and child health.	Healthy Start staff, computers, cameras, internet access, printing company, mailing labels, postage machine	Newsletter was restarted in August 2004 in order to inform the community about maternal and child health issues. In particular, this program wanted to try to begin to break down the barriers that keep participants from accessing the medical and mental health services they need.

C.

An event which detracted from the successful initiation and implementation of the depression screening and referral component was the difficulty in hiring a licensed social worker to develop and coordinate this component of the program. Early in 2002 a social worker was hired but later resigned. Hiring for this position remained problematic.

The nurses at this time were only screening those participants who had self-reported depression and they were using the Beck's Depression Inventory. In May 2002 Healthy Start, along with the Allegheny County Health Department, sponsored a forum on postpartum depression. The Edinburgh Postnatal Depression Scale was demonstrated at this forum and this program began universal screening of participants using this instrument in September of that year.

These problems would account for the numbers of screenings being lower than intended for the first two years. In 2002, the number of screenings from September to December was 217. In 2003, the number of screenings was 537, for a total of 754. The projected number was 925.

In November 2003, a licensed social worker was hired and a screening protocol was developed. The nurses were now able to screen participants on a more consistent basis and to refer participants to the social worker or other mental health providers based on the participants' scores. The participants' scores along with other information are consistently entered into a database which is exclusively for depression screenings. The database is used to monitor whether participants' treatment (if they chose to receive any) is having any effect on their well-being. It can also be used to assess the rates at which postpartum depression occurs in our target population. The program assistants have programmed their computers to notify them about which participants are due for their 6-month depression screening. This was done in order to prevent those participants who did not screen positive for depression on their previous screening from going unidentified if symptoms developed later in their enrollment. This information is given to the nurses who are then able to schedule a depression screening for those participants.

In 2004 the number of screenings was also fewer than had been projected. There were 696 screenings conducted and 1,000 had been projected. This could be explained by the reduction in the number of staff nurses due to two resignations and one sick leave. Nurses were hired from a temp agency to fill in, but this affected the regularity with which the depression screens were being done.

In January 2005 this Healthy Start program established a relationship with the University of Pittsburgh's School of Social Work internship program. The licensed social worker attended a series of field instructors' seminars which qualified her to become a field instructor and have a student from the school of social work complete an internship at Healthy Start. An intern began working at this program in March 2005 and completed her Foundations field placement in June 2005. While she was here, she assisted the nurses in conducting the depression screenings based on the information from the program assistant. From January to May of 2005, 229 screenings were conducted.

Local Health Systems Action Plan

A.
Developed in 2000, with input from the Allegheny County Health Department and Healthy Start, Inc.'s Board of Directors and the six Regional Consortia, the Local Health Systems Action Plan identified health improvement priorities and encouraged development of a coordinated system of prevention, social and personal health services in the county's perinatal system.

The Local Health Systems Action plan

1. set priorities for Healthy Start case management and health education core service interventions,
2. established goals and objectives and mapped progress on those goals,
3. guided engagement and direction for Consortia, key stakeholders and the community

B.
The priorities for the LHSAP were identified through various sources such as Healthy Start case management data, Pennsylvania Department of Health/Bureau of Family Health, Division of Maternal and Child Health lock Grant Needs Assessment and the established Healthy People 2010 maternal and child health goals and objectives and the Allegheny County Health Department Needs Assessment.

The Healthy Start, Inc. staff and the Health Department Maternal and Child Health program staff were primarily responsible for meeting the goals of the Local Health Systems Action Plan.

Early in the process, the Healthy Start Consortia identified key priority issues related to perinatal health, such as immunizations and interconceptional health, among others.

A comprehensive study conducted y RAND-University of Pittsburgh Institute (funded by the Heinz Endowment Foundation) made recommendations on ways to improve maternal and child health care service delivery and outcomes in Allegheny County communities. As a result of the study, a community-based Improvement Team was established in one of the target area's community health center's to focus on behavioral health issues, particularly depression in women.
Pittsburgh/Allegheny County Healthy Start was recognized in the study as a "best Practice model.

The Health Department developed and published a strategic plan through a process
That included input and broad representation by many agencies, organizations and disciplines. Issues assessed as top priorities included eliminating the disparities in healthcare, improvement in public education on health and mental health, wellness and safety issues, and the creation of a true public health system for the county through planning, coordination and cooperation.

C.
There were no particular challenges, beyond the routine, in developing the Local Health Systems Action Plan. Priorities for the Healthy Start project were already set and the community realized that systematic changes needed to occur to improve the health in maternal and child health, especially within the African-American population.

However, there were challenges faced in implementing the local Health Systems Action Plan. They included

- the slow process in achieving measurable goals and change,
- shifting priorities within the public health system in this new age of "bio-terrorism" and
- a lack of financial resources to implement requisite system changes

Consortium

A.
The approach to successfully reduce infant mortality/deaths and reverse the ever-widening gap between the races required a comprehensive and intensive community-wide and community-based support system. The structure in place for the last fourteen years is known as the "Bottom-Up Approach" it includes a voluntary eighteen member Board of Directors and six Regional Consortia. The Board of Directors is responsible for setting policy and guiding program direction. The six Regional Consortia served as an advisory to the Board. All recommendations from the entire Consortia are filtered down to the program which then implements service. This unique structure has been the catalyst for the community-driven approach that is sensitive to the needs of the at-risk population for Pittsburgh/Allegheny County. The Board of Directors and the six Regional Consortia are comprised of consumers, neighborhood organizations, religious leaders, business professionals, youth, elected officials, health and human service providers, and members at large. This collaboration of predominantly African-American and White females and males of varying age organized under the auspices of Healthy Start, Inc. came together as a structured focus body to accomplish the goals and objectives in a collectively applying resources and strengths to address infant mortality.

The rationale for community involvement was based on the feedback from community forums, focus groups, and town meetings. From these meetings came the strategy that addressing infant mortality would require more than a medical model; it would require ownership from the community and their involvement at all levels of planning and implementation for attitudinal change and infant mortality reduction to occur.

The strengths of the community included the Consortia's ability to act as the eyes and the ears of the community and serve as the "voice" for advocacy for the at-risk population. Consortia members lead community mobilization efforts and initiatives to enhance knowledge of infant mortality and elimination of health disparities in their communities. Over the last four years, members were responsible for identifying the target population, heightening public awareness about infant mortality, planning and developing culturally sensitive marketing tools and activities, strengthening collaborations with systems, identifying service strengths and weaknesses, and monitoring service delivery for cultural sensitivity and appropriateness, and monitoring of program effectiveness and delivery. Consortia members have identified the need for depression screening, increased amount of outreach/recruitment activities, recommended changes to case management delivery systems to include home visiting based on participant level of risk, and participated in the development of quality assurance practices as it relates to the referral system internally and externally.

The Consortia have evidenced over the last four years the impact that can made through their involvement as they utilized the strengths they have among membership to resolve gaps in services. Members have developed referral systems among providers to eliminate gaps in service between agencies for families. Members have also worked together to streamline services to decrease duplication of services for families utilizing multiple programs. Members have trained each other in multiple areas including organizational skills, program capabilities, grant writing, and strategic planning.

B.
Healthy Start, Inc. has since 2001 dedicated a full-time Regional Advocate position under the supervision of a Field Manager to facilitate Consortia meetings and activities. In addition, Multidisciplinary Team members assisted in all Consortia activities. During the four year period, Healthy Start experienced turnover in the Regional Advocate position. This turnover caused a decline in Consortia meetings and increased loss in membership. Since November of 2003, the Regional Advocate position has been filled and regular meetings have ensued as well as tremendous increase in membership and participation. The Regional Advocate was able to regain the respect and support of the Consortia and reestablished relationships with key members and organizations. The task was difficult to shift individual priorities to refocusing strengths in the direction of the Healthy Start mission. By January of 2004, over eighty-percent (80%) or one hundred and six (106) members of the existing membership were retained and twenty (20) new members were recruited including an unprecedented number of program participants at twenty-five percent (25%) or five (5).

In June 2004, employment structures were changed to maximize utilization of staff. The Regional Advocate position was enhanced and changed in title and capacity to Perinatal Systems Liaison under the supervision of the Executive Director. This change allowed more responsibility, flexibility, and specialized attention to Consortia management.

C.
The primary changes to Consortia management included the development of a database to track members, their attendance, and volunteer hours. This database centralizes Consortia information and filters data and makes it readily accessible when needed.

Due to funding cuts on the state and federal level attendance and participation by key local providers in the community has decreased. However, agencies have not lost interest in the Consortia or its mission and local providers remain dedicated to Healthy Start. To assist those individuals a volunteer database was developed to serve as a resource directory and it is used when the Consortia need help advocacy projects, presentations and trainings, or activities.
In addition, the Consortia has received funding cuts that has forfeited their ability to seek out contracted services and meet all of the needs of the participants such as tangible needs, i.e. cribs, car seats, and strollers. The Consortia continued work to identify funding replacements throughout the period including identifying funds to reinstitute the company newsletter, participant incentives, and educational activities in their communities.

D.

1.
In 1991, the original architects were in agreement that successful efforts to reduce infant mortality/deaths and reverse the cycle of an ever-widening gap between the races required a comprehensive and intensive community-wide and community-based effort.

Establishment of the Consortium was achieved through use of mass media tools such as local newspapers, television, and radio to heighten awareness about the Project and the problem. The original planners set out to garner community support through various activities such as town meetings, forums, and focus group interviews.

From these meetings a Project Area Consortium was developed comprised of consumers and advocates, and members who served as heads of major organizations or institutions in government, specialty human services, medicine, private philanthropy, and education. Each of these individuals was selected by the Chairperson of the Allegheny County Board of Commissioners. The goal of the Project Area Consortium was to serve as the primary advisory arm of the program ensuring that the systemic, strategic vision of the project was realized throughout all program initiatives. The Project Area Consortium specifically set project direction, advised on project activities, and promoted community outreach and public awareness of infant mortality and of initiatives to reduce it.

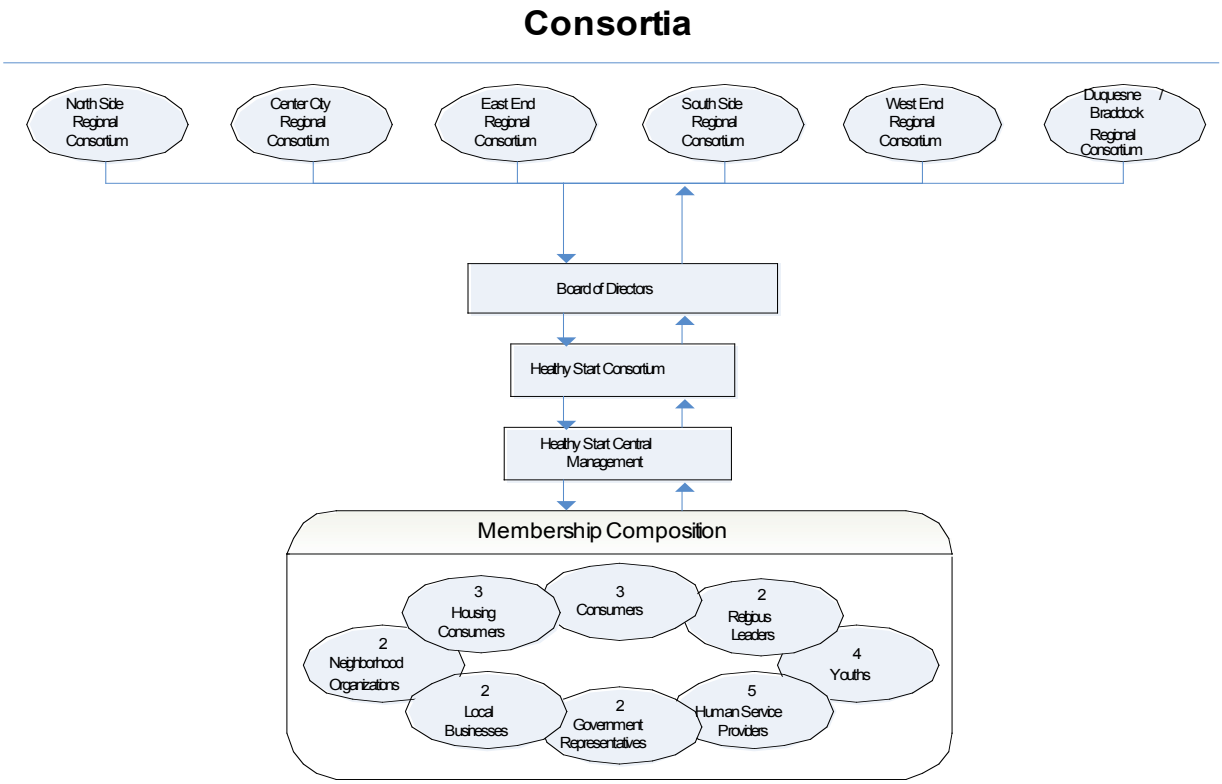
Because the Healthy Start Project Area was comprised of six (6) service areas, primarily within the City of Pittsburgh, and included four (4) municipalities in Allegheny County, outside the city. These areas were targeted because they accounted for 43% of the infant deaths in Allegheny County, and 79% of those were in the city. Given the fact that the project covered six separate and distinct geographic locations, community representation from these areas was an important factor in achieving credibility among the target populations. To ensure that each community was represented and individual community needs were addressed the Project Area Consortium developed the Healthy Start Comprehensive Plan.

During 1992, Year 02, the Project Area Consortia was instrumental in developing the Healthy Start Comprehensive Plan. The comprehensive plan consisted of a community-based governance included was a Board of Directors and six Regional Consortiums which are still represented today.

2.
The current working structure for the Consortium continues to be the catalyst for reducing infant mortality and instances of low birth weight babies in Pittsburgh. The eighteen members voluntary Board of Directors serves as the central overseer of the project, while the Six Regional Consortia are advisors to the Board of Directors. Six seats on the Board of Directors are reserved for consumers this provides and assures one-third of the vote has community interest. One community or consumer representative from each of the Six Regional Consortia fills those reserved seats. The composition of the Consortia was strategically designed to maximize the resources of the entire community in order to make the greatest impact. Regardless, of changes

in the community the structure of the Consortia allows for flexibility and assures community input.

The consortium membership has been as high as one hundred sixty-six (166) and as low as one hundred nine (109) between the Board of Directors and Six Regional Consortiums during the four year period. Members actively attend regular monthly or bimonthly meetings, participate in Healthy Start activities, and form partnership/alliances on special projects. The figures and Organizational model below provide details of the Consortia composition and design.



Categories	State & Local Government	Program Participant	Community Participant	Community Based Organizations	Private Agencies	Providers Contracting with HS	Other Providers	Other
Percentage	10%	15%	35%	25%	15%	0%	N/A	N/A

Targeted Area Participant	White	African-American	American Indian and Alaskan Native	Asian	Native Hawaiian and Other Pacific Islander	Hispanic and *Latino	Other	Unknown
Percentage	39%	60%	1.0%	0.0%	0%	0.0%	0.00%	0%

3.
Consumers have been involved at every level of the program. Each Consortium continued to hold regular meetings throughout the four-year and meeting frequency was determined by voting members. Regional Chairs and Vice Chairs were elected from each region and met quarterly to

address the needs and concerns of the Consortia, plan special events, and discuss education/training and models of intervention.

Over the four-year period, the Consortia planned and implemented nineteen educational community baby showers. These baby showers served as an educational venue that allowed interactive learning for participants and their families. The baby showers have also served as a recruitment tool for the Consortia in gaining access to participants for membership.

Regional Consortia orientation was held at a minimum of once a year for all regions. These events allowed for the Board Chair, Executive Director, and staff the opportunity to discuss the national overview, community partnerships and collaborations, member responsibility and Consortia management and field direct services questions.

Each year, members were recognized at the Volunteer Recognition. This event allowed recognition of Consortia members and partners for their service collaboration with Healthy Start Pittsburgh.

Frequently, Consortia members also participated in advocacy campaigns. Issues addressed were sustainability, malpractice insurance, fees for service, access to care, and welfare reform changes. Members received updates regularly relative to changes in legislation, medical updates, and recalls.

Consortia members participated in focus groups twice a year to monitor the Local Health Systems Action Plan (LHSAP) frequently revisiting it to ensure it is accurate in reflecting the needs of the community. Members also participate in several surveys throughout the year focused on identifying gaps in service or comments or suggestions on program direction. Members hold seats on National, Local, and Statewide alliances and organizations to monitor and remain aware of environmental or governmental changes and issues that may arise and affect the program and its ability to operate effectively.

In 2001, the Chair of the Healthy Start, Inc., Board of Directors was elected to the National Healthy Start Association Board of Directors and in 2004, he was appointed Co-Chair of the association's sustainability committee.

4.
The mission to create and coordinate a comprehensive service delivery system that makes accessible all preconceptual, pregnancy, and parenting services that ensure infants are born healthy into homes where they were nurtured and valued. These services are targeted toward reducing social, physical, emotional, and psychological risk factors, as well as enhancing community and individual sensitivity and commitment to the quality of life.

Partnerships have emerged, strengthened, and created a network of service collaboration, innovation, and changed the way service providers do business. The role of the non-profit has combined the strengths of a larger bureaucracy with the flexibility of a community-based public/private entity in which participants and providers have a shared voice in maintaining the vision of the project. The main shared vision has been to encourage grassroots participation and

involvement by the community in establishing and carrying out programs. This can only be achieved through ownership, empowerment, and collective responsibility. The shared decision making of the members has led to a greater understanding of, and commitment to, the project goals.

Healthy Start, Inc. has provided extensive and comprehensive training for members to achieve cooperation and teamwork from the community. The strengths of the community include their ability to accomplish the goals of the project including serving as the "voice" for those families who are at-risk for poor health outcomes. In the four year period the Consortia have successfully made valuable use of the diversity among them and have utilized each others talents and expertise.

Collectively members have committed thousands of volunteer hours, advocated for social change, and dedicated attention to individual communities and families in Pittsburgh/Allegheny. Members have spent approximately eighteen thousand (18,000) hours or half of the four years in meetings, canvassing, planning and implementing activities, and heightening public awareness about infant mortality. Members have signed several petitions in efforts to thwart governmental cuts to Medicaid for low-income families, Temporary Assistance to Needy Families (TANF), and Healthy Start projects nationally. In addition, over forty-percent (40%) of the current members have been dedicated to the project since the inception and were involved in the initial planning.

5.
Some of the barriers that have affected the Consortia in the four year period included meeting attendance, transportation and childcare, meeting times and locations, and a dedicated staff person.

One of the barriers during the four year period was retaining a full-time Regional Advocate dedicated to facilitating Consortia activities. The Consortia were impacted by two turnovers between 2001 and 2003. The turnover in staff forced management to make the decision to only conduct meetings with the Chairs and Vice Chairs until a full-time person was hired. The decline in meetings proved to adversely affect membership resulting in decrease. Staff and Consortia relationships and team efforts are instrumental in maintaining the participant-driven approach of the program. The barrier was resolved at the end of 2003 when the Regional Advocate position was filled and regular meetings ensued as well as a tremendous increase in membership and participation. The new Regional Advocate was able to regain the respect and support of the Consortia and reestablished relationships with key members and organizations. The task was difficult because there needed to be a shift in individual priorities towards refocusing strengths in the direction of the Healthy Start mission. By January of 2004, over eighty-percent (80%) or one hundred and six (106) members of the existing membership were retained and twenty (20) new members were recruited including an unprecedented number of program participants at twenty-five percent (25%) or five (5).

The most common barriers that consumers encounter in Consortia involvement are the very same things that face the typical Healthy Start participant: transportation and childcare. To overcome

these barriers Healthy Start provides transportation and childcare and meetings are held conveniently in their communities.

However, the greatest barrier to affect the Consortia in the four-year period is lack of funds. In the beginning the Consortia budget was approximately $900,000.00 and they were responsible for obtaining contracts for service, and planning activities and special events. Over the last four year period, the Consortia budget took a dramatic decrease. Each of the regions receive approximately $11,000.00 to produce six (6) community baby showers, six (6) health fairs, six (6) community canvassing events annually. This shortage of funds has forced them to change directions and pursue other funding and collaboration options.

6.
In 1992, Healthy Start instituted a comprehensive plan of action to address the concerns identified by consumers relative to their participation in Consortia activities. Healthy Start continued to utilize this plan during the four year period as it achieved the best results in retaining and recruiting the participation of consumers. The plan as developed is sensitive to the social, economic, and developmental needs of the consumer membership.

Healthy Start found that the following strategies have been successful at increasing and retaining the membership of consumers including transportation and childcare reimbursement for meetings and approved Healthy Start activities; one hour meetings that are localized by region (community); nutritional supplements provided at meetings and approved Healthy Start activities; individual mentorship toward improving advocacy and leadership skills; sensitivity to the community "voice"; utilization of their suggestions and advice; computation of volunteer hours as required by the Department of Welfare; involve consumers at all levels of the program; employ consumers; give consumers the opportunity to serve in an advisory capacity (Board of Directors); and consumers are able to acquire skills through training that enhance their employability or leadership development. These strategies are documented successes through monitoring of satisfaction surveys, focus groups, community assessments, retention rates, and cumulative participation.

7.
As strategically designed and implemented the structure and By-laws that governs the Consortia allows maximum "voice" by consumers in the decision-making process. Consumers made up thirty percent (30%) or one-third of the total membership in the last four years. Healthy Start continues to promote and encourage consumers to have a "voice" and share in the decision-making by involving them at every level of the program.

During the four year period consumers served as advisors and monitors to the Healthy Start strategic plan process. It is through this collaboration that design and implementation of strategic plans were developed and effectively disseminated in the community to reduce infant mortality and eliminate disparities in perinatal health.

Consumers on the Board of Directors will serve as members on the five following committees: Finance, Personnel, Marketing, Quality Improvement, and Executive.

Finance Committee - Consumers oversee all budgetary items for the organization in collaboration with the Allegheny County Health Department. This ensures consumers are involved in the fiscal integrity of the program. Consumers advised on activities related to the budget, allocation of funds, and identified funding gaps and improvements.

Personnel Committee - Consumers actively participated in the recruitment and interviewing of indigenous staff members.

As Personnel Committee members, consumers worked with the Human Resources Manager advising on hiring practices, policies and procedures of the employee handbook, providing input on job descriptions, and making referrals to Healthy Start for employment to ensure the overall personnel design is aligned with the needs of the indigent staff.

Marketing Committee - Consumers monitored and assisted in the dissemination of educational materials to the community. As marketing committee members they held responsibility for the public image of Healthy Start and ensuring that flyers, pamphlets, and educational materials are sensitive to the targeted population.

Quality Assurance Committee - Consumers evaluated and monitored services, statistical reports, and policies/procedures of the program assuring that it is aligned with the objectives of the program. The consumers also evaluated the program objectives to reinforce there successful delivery to the community.

The Executive Committee – Consumers continued to actively seek funding opportunities to sustain the life of the Healthy Start program. The Executive committee is composed of the elected officers on the Board of Directors including the Chairperson, Vice Chairperson, Treasurer, and Secretary.

8.
Healthy Start utilizes the suggestions of consumers by implementing program objectives to facilitate their ideas. Several of our program models and activities are examples of consumer suggestions over the four year period.

Components	**Activity**	**Outcome**
Community Activities	(19)baby showers (2) Baby's 1st birthday (144)community meetings (10)health fairs (43)community events (4) volunteer recognition	1,200 participants attended 100 families attended 576 members attended 2,000 attended 8,600 attended 1,000 attended
Outreach & Enrollment	(4) Community canvassing activities	20,000 brochures, pamphlets distributed 11 new indigenous employees hired 40 new consortia members including youth and consumers
Advocacy	(4) Capitol Hill visits (4) National Committee Assignments (1) Congressional letters (1) Medicaid cuts campaign with the Consumer Health Coalition and Just Harvest	6 consumers attended 6 members hold seats on the National Healthy Start Association Sustainability and Development committees 6,000 signatures received 11,000 signatures received
Sustainability	(2) Department of Community and Economic Development Grants (1) Community Development Block Grant	$10,000 to expand company newsletter $5,000 to reinstate incentive program $1,500 to provide training and incentives

Collaborations and Coordination with State Title V and Other Agencies

A.
A central feature of the Pittsburgh/Allegheny County Healthy Start design is collaboration; specifically the building of partnerships at the community level and among county-wide systems in order to create a seamless continuum for services for families at risk of infant mortality and health disparities. This has led, over the course of the initiative, to new and nontraditional institutional alliances.

During the planning process it was determined that the key element to continuation of the Healthy Start initiative when federal funding was withdrawn was the extent to which existing systems of care had been altered to accommodate the special needs of at risk women and infants. As a result Healthy Start, Inc. continues it broad based collaboration at the local, state and national levels.

The Healthy Start, Inc. Board of Directors determined that the Healthy Start project would be the vehicle to strengthen ongoing collaborations, bridge gaps, obviate duplication, and enhance consciousness of the interrelated medical and social risk factors associated with infant mortality and move health and human service providers to adopt more holistic approaches.

B.
Collaboration has been and continues to be a primary role in the development, implementation and sustainability of Healthy Start, Inc.

Enhanced collaboration between established health and human service providers was one of the major results that emanated from the development of public-private partnership. These partnerships provided consumers and participants in the Project Area with a more integrated system of care. In addition, it brought structural changes to the relationships between Healthy Start, Inc and established health providers through formalized agreements starting with the Allegheny County Health Department

The Allegheny County Health Department, the Healthy Start, Inc. grantee until May 1, 2005, is also the local Title V Maternal and Child Health agency as well as the Local WIC provider for Allegheny County. In the beginning, this relationship/collaboration ensured effective coordination with the Healthy Start project.

At the local level, Healthy Start and the Allegheny County Health Department have worked collaboratively with the Consumer Health Coalition to promote the Children's Health Insurance Program (Title XXI) as well as holding numerous discussions with the three Medicaid (Title XIX) Managed Care Organizations to provide a seamless case management approach for families being served.

The health education component of Healthy Start has engaged in a number of partnerships to reach vulnerable teens and families where they congregate naturally; places where they can be reached in a non-stigmatizing, now-threatening way.

Healthy Start, Inc. partners with the Pittsburgh Board of Public Education, Woodland Hills and Wilkinsburg School Districts. The services range from support for pregnant and parenting teens (females and males), health education classes, technical assistance in curriculum development and immunizations. In addition, the Woodland Hill Superintendent is a member of the Healthy Start, Inc., Board of Directors and the Superintendent of Wilkinsburg sets on the Region III Consortia.

The two federally funded community health centers in the Healthy Start Project Area (Primary Care Health Services, Inc. and Sto-Rox Family Health Center) are active members of the Regional Consortia and the Healthy Start, Inc. Board of Directors.

Primary Care and Sto-Rox have collaborated with Healthy Start, Inc. on national health promotion such as, "Take A Love One to the Doctor Day" and Women Health Awareness Day.

The Pittsburgh/Allegheny County Healthy Start program participated in the (Tri-borough, Mon Valley and McKeesport) perinatal initiative Communities that Care.

C.
In the Commonwealth of Pennsylvania, the Bureau of Family Health within the Department of Health is responsible for the Maternal and Child Health Services Title V Block Grant.

The Allegheny County Health Department, the local Title V agency, administers the Maternal and Child Health program for Allegheny County, thus ensuring effective coordination and shared resources with the Healthy Start program. The MCH Services Block grant funds represent approximately one-third of the local Maternal Child Health programs.

The Healthy Start, Inc. Help Line continued to serve as a primary link with the state information line. The Helpline is staffed from 8:00 a.m. to 10:00 p.m. daily, including weekends and holidays.

Another example of a local Title V/Healthy Start, Inc. linkage is the Healthy Start Helpline telephone number 412-247-1000. This number serves as the Allegheny County Breastfeeding Helpline. The Help Line is staffed by International Board Certified Lactation Consultants funded by Title V and Healthy Start. Since 1992, the number has been given to all breastfeeding mothers upon hospital discharge following delivery.

The health of mothers, infants, children and adolescents continues to be a major priority for the Commonwealth of Pennsylvania's "Perinatal Partnership". Since 2000, the PA Department of Health's MCH Title V staff and the Pennsylvania Healthy Start Projects have initiated meetings for the purpose of coordinating plans and resources in an effort to enhance access to and utilization of perinatal systems in the state. The PA Perinatal Partnership meetings are ongoing.

The mission of the Partnership is "to improve perinatal health outcomes in Pennsylvania through collaboration, intervention, joint strategies and advocacy". Participants include representatives from the Healthy Start projects, Medicaid (Healthy Beginnings Plus), County/Municipal Health Departments and the State Health Department Maternal and Child Health Program. The Health

Insurance Portability and Accountability Act and medical liability issues related to access to care are examples of the Partnership focus. The Allegheny County Health Department Maternal Child Health Program Chief served as one of the co-chairs of the Pennsylvania Perinatal Partnership. The other co-chair represents Pennsylvania Healthy Start Projects.

The Pennsylvania Perinatal Partnership Publication entitled "Pennsylvania Healthy Start" continued to be an effective advocacy and educational document in 2004.

In 2003, the Partnership was acknowledged as a national model of Healthy Start/Title V Collaboration. The organization is an authentic partnership between Healthy Start and Title V that emanated from commitment and not simply in response to financial or regulatory requirements.

The Pennsylvania Perinatal Partnership, initiated sponsorship of a workshop in conjunction with Health Resource and Service Administration (HRSA), "Bridging Cultures and Enhancing Care in Pennsylvania". The workshop brought together Pennsylvania Medicaid, SCHIP (State Children's Health Insurance Plan), Department of Welfare, Health and Insurance Officials, Medicaid Managed Care organizations and SCHIP providers, Healthy Start and Title V staff to improve cultural/ethnic competency and sensitivity. A comprehensive resource guide including references and web sites was provided to participants and made available throughout the state.

Pittsburgh/Allegheny County Health Start's collaborations and service coordination included the University of Pittsburgh (Graduate School of Public Health, School of Social Work and Center for Minority Health) and CityMatCH (Perinatal Period of Risk).

Locally, Healthy Start continued to participate in the Home Visiting Network. Under the direction and guidance of the Healthy Start Executive Director and the Project Director, the Home Visiting Network composed of 42 maternal and child health and home visiting agencies share information, train members, facilitate consumer provider resource information, provide legislative advocacy and managed care monitoring.

Since 1999, Healthy Start has contracted with the Allegheny County Health Department Resource Mothers project, a Title V funded program for fiscal administration. In 2001, Healthy Start assumed responsibility for the direct service delivery for this program.

Healthy Start, inc. and the Allegheny County Health Department Maternal Child Health Program successfully secured Pennsylvania State grant funding for the Nurse Family Partnership Program. The Nurse Family Partnership initiative was spearheaded by the Governor's Partnership for Safe Children. The Nurse Family Partnership, funded by the Pennsylvania Department of Welfare/Tangible Aid for Needy Families and the Pennsylvania Commission on Crime and Delinquency, the Nurse Family Partnership program provides home visiting to income eligible first-time mothers through a child's second birthday. A Steering Committee consists of representatives from the University of Pittsburgh Medical Center affiliates, Shadyside Hospital and Latterman Clinic (community-based clinic), and a representative form the University of Pittsburgh Office of Child Development. Staff is co-located with Allegheny County Health Department Maternal Child Health Program staff and a Maternal Child Health

Nurse Administrator provides direct program oversight. The Healthy Start Executive Director and MCH Program Chief provided overall direction for this program.

The Allegheny county Child Death Review Team (CDRT) served and continues to serve as an interagency quality assurance team that reviews childhood deaths from birth to eighteen years of age. From 1991 to 1997, the Child Death Review Team provided Health Start data on infant deaths in the Project Area. The Healthy Start Executive Director, the Data Analyst and a Field Manager serve on the Child Death Review Team.

The political environment for Healthy Start Pittsburgh remains highly supportive. Elected officials attend regular meetings and community-based activities, inform about funding opportunities and make staff available to answer the concerns of consumers.

Sustainability

A.
With regard to sustainability, the Pittsburgh/Allegheny County Healthy Start project has participated in and pursued several efforts in an attempt to identify and obtain resources that can sustain Healthy Start, Inc. beyond reliance on federal funding.

Healthy Start, Inc. approaches sustainability and focuses on the following:

- Efforts to ensure sustainability with State authorities by advocating for increased services for children and maximizing Title V funding priority areas.
- Identification of the most successful program elements and documentation of their cost effectiveness with emphasis on key community-based services.
- Further exploration of a diversified funding base that includes insurance reimbursement, public program funding and private philanthropy

B.
Since the creation of the non-profit Healthy Start, Inc., in 1992, the Healthy Start, Inc. Board of Directors, the six Regional Consortia, the Executive Director and other Key Personnel have made sustaining the non-profit a priority and they have assumed responsibility for this task.

Early on in the planning and implementation process it was recognized that foundation grants will not sustain a program over time. However, it was also recognized how extremely valuable foundation could be in supporting innovation approaches. Therefore, the involvement of the corporate and philanthropic communities was sought and garnered. To date, they continue to play a significant role in funding innovative approaches and demonstrations.

C.
Aggressive marketing efforts by staff and the expressed support by local news media of Healthy Start's approach heightened the receptivity of local funders to invest in prevention and early intervention initiatives. Sustaining this interest has continued to be a priority for the grantee, the Healthy Start Board of Directors and the staff.

Another example of sustainability with the Project is the Nurse Family Partnership program. Funded by the Commonwealth of Pennsylvania's Department of Welfare (TANF funds) and the Commission on Crime and Delinquency, in 2001, this program provides an opportunity for 110 first time moms to receive home visitation through Healthy Start.

The Allegheny County Health Department contracts with Healthy Start, Inc. for the administration and management of the Resource Mothers Project.

Local churches, hospital, service providers, schools/colleges and businesses donated their offices for Regional Consortia meetings.

Area businesses, specializing in novelty items, have provided Healthy Start with incentives at reduced cost or for free. The incentives were distributed at local health fairs, baby showers and community days.

Healthy Start, Inc. was selected to receive $1,500 from one of the local television stations for an education program. As determined by the Board and staff, the money was used to develop and print a pamphlet on colds and flu, purchase special thermometers for case managed participants and underwrote a breast cancer awareness campaign.

Healthy Start enjoys a rich relationship with several local universities and colleges. Staff members from these institutions have donated their personal time, reviewed grants, provided technical support, facilitated in-service trainings and provided access to and referred students who were looking for field placement experience to Healthy Start, Inc.

A long-term sustainability effort involves the securing of $140,000 form two local foundations (R.K. Mellon and one which wishes to remain anonymous). These funds were obtained so that the Fayette County Healthy Start Initiative could purchase a facility to house the project in that community.

Healthy Start, Inc. leases office space to Southwest Pennsylvania Area Health Education Center (AHEC).

Healthy Start, Inc. is the fiscal conduit for the AmeriCorps program.

E.

1.
In 1995, Healthy Start, Inc. approached Medicaid managed care organizations and their licensing authorities to include Healthy Start services in their benefit plan and to encourage the PA Departments of Public Welfare and Health to include Healthy Start as a required option for Medicaid clients. The process has been slow and without results. To date, Healthy Start, Inc. does not have a duly executed contract. We continue to be optimist that this collaboration will move us in the direction of an ongoing source of revenue.

2.
Healthy Start, Inc. has developed specific "case statements" that include key elements of consideration for potential funding sources, policy makers and elected officials.

Healthy Start, Inc. has focused on identification of the most successful program elements and documentation of their cost effectiveness with emphasis on key community-based services.

Healthy Start, Inc. continues to explore a diversified funding base that includes insurance reimbursement, public program funding and private philanthropy.

The project expanded its programming efforts into Southwestern Pennsylvania. In 1999, Healthy Start, Inc. secured an infrastructure and capacity building grant for Fayette County, Pennsylvania. The following year, the non-profit Healthy Start, Inc. became the grantee for the Fayette County Healthy Start initiative. This rural disparities project is located approximately 50 miles south of Pittsburgh in Fayette County.

Healthy Start's most success effort to date regarding long term sustainability involves the securing of $140,000 from two local foundations. These funds were obtained so that the Fayette County Healthy Start initiative could purchase a facility to house the project in that community.

A four year grant from the Heinz Foundation has enabled Healthy Start, Inc. to extend beyond the original Healthy Start Service area and to provide case management and care coordination service to high risk males and females residing in the communities of Penn Hills, Tarentum, Lawrenceville, Sheraden and Homestead.

III. Project Management and Governance

A.
Each year, an agreement was negotiated between Allegheny County Health Department and Healthy Start, Inc. This agreement clearly delineated the respective responsibilities of the two organizations, facilitated the operation of the initiative and improved communication between the grantee and non-profit.

The management and governance which was in place for the majority of the project's implementation included the Allegheny County Health Department (grantee), Healthy Start, Inc. (non-profit), the Healthy Start, Inc. Board of Directors and the Regional Consortia.

The Allegheny County Health Department, in its role as grantee, had the overall responsibility for the administrative and financial management of the grant. The Health Department, a nationally recognized public health program, known for its leadership in the development of programs focused on high-risk women and children had been central to the project in its role as grantee.

Incorporated in 1991, Healthy Start, Inc. was designed to streamline the administration of health initiatives such as Healthy Start and other federal and state funded maternal and child health

projects undertaken by the Allegheny County Health Department. Healthy Start Inc., had responsibility for hiring and training staff, the day-to-day program and fiscal operations.

The Healthy Start, Inc. Board of Directors composed of eighteen recognized leaders from established institutions and agencies in Allegheny and Fayette County, Pennsylvania set policy, elected corporate officers, hired the executive director, provided overall direction and approved the overall budget.

The six Regional Consortia, products of the Healthy Start community planning process, provided vital feedback from the community perspective, advised the Board, monitored program implementation and Core Team activities, made fiscal decisions for their communities, and assisted with community education and advocacy efforts.

In 1999, the non-profit Healthy Start, Inc. applied for and received a Health Resource and Service Administration (HRSA) Infrastructure and Capacity Building award, and in 2000 Healthy Start, Inc. became the grantee for an Eliminating Disparities in Perinatal Health project located in Fayette County, Pennsylvania 50 miles southwest of Pittsburgh.

In 2004, with the non-profit's mature management/administrative infrastructure in place, it was felt that this was the time for the formal change in the actual grantee in order to provide for a seamless transition from county government to community-based non-profit.

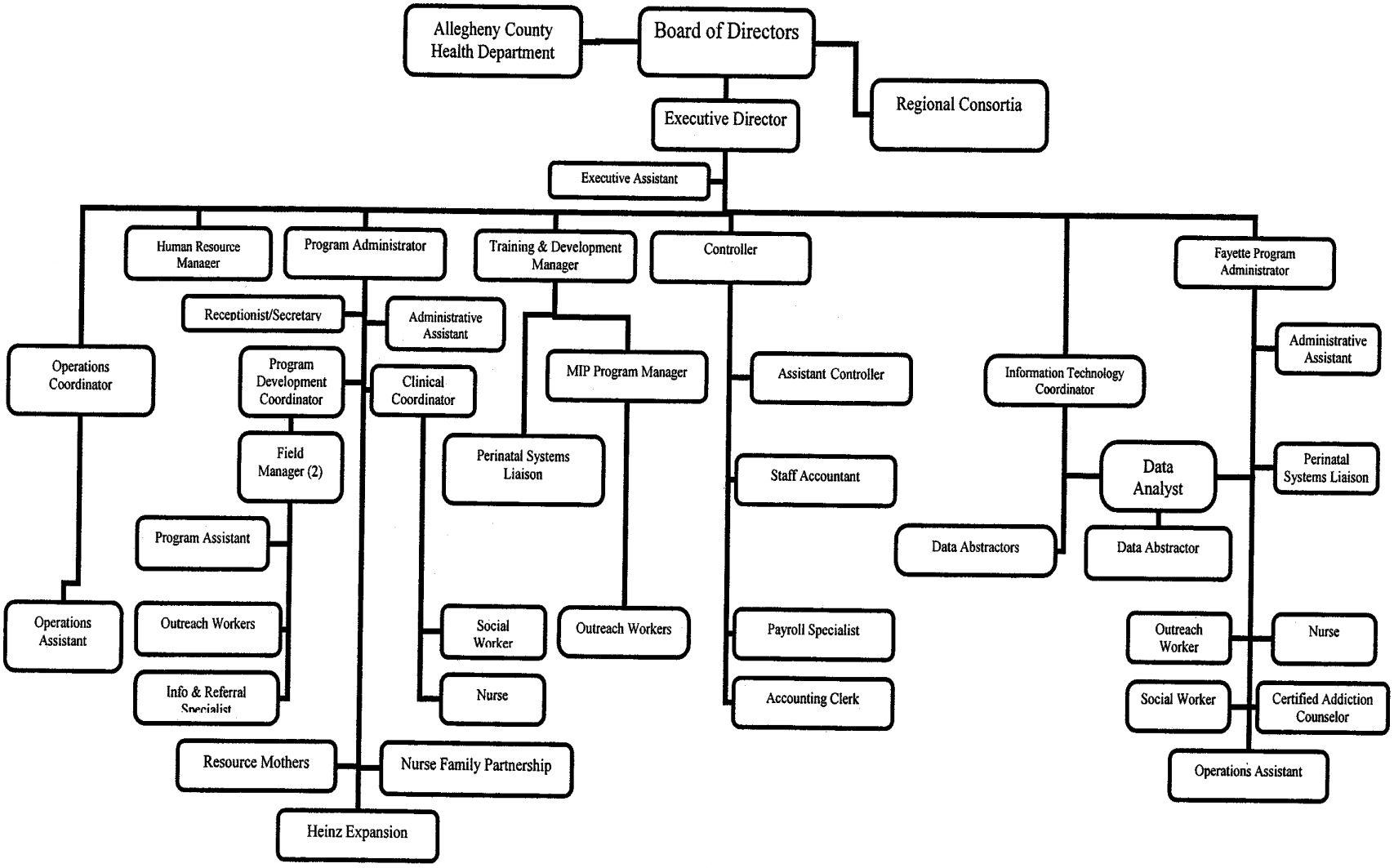
Not only had Healthy Start successfully managed the Healthy Start grant for Fayette County, Pennsylvania, the Allegheny County Health Department continued to face serious cutbacks which had burdened and diminished its ability to devote resources to community initiatives beyond its primary mandate.

Thus, in December of 2004, with the blessings of the Allegheny County Health Department, it was the non-profit Healthy Start who applied as successor grantee for the Pittsburgh Healthy Start project with the Allegheny County Health Department taking on the role of advisor, providing technical expertise and funder for various Maternal Child Health projects contracting with Healthy Start, Inc. The process utilized is outlined below.

In March 2003, the Chair and Vice Chair of the Healthy Start, Inc. Board of Directors and the Executive Director commenced discussions with the Pittsburgh Project's Grants Management Specialist and the Division of Healthy Start Program Officer on transitioning project funds and grantee responsibilities to the non-profit prior to the May 31, 2005 project end date.

On April 30, 2005, the HRSA Grants Management office transferred the remaining Pittsburgh Project funds from the Allegheny County Health Department to the non-profit Healthy Start, Inc. and on May 1, 2005, the Health Resource Service Administration (HRSA) Grants Management office succeeded grantee responsibility to the non-profit Healthy Start Inc.

Pittsburgh/Allegheny County Healthy Start
Organizational Chart



B.

At the on-set of the project, the Allegheny County Health Department, the grantee for the majority of the project period, and the newly created community-based non-profit Healthy Start, Inc. established firm fiscal monitoring and program oversight. The Allegheny County Health Department provided technical assistance, helped publish documents, and members of their staff donated numerous hours serving on the Consortia and the Healthy Start, Inc. Board of Directors. In addition, the Health Department staff provided staff training, free immunizations for all Healthy Start, Inc. staff, performed program file audits, reviewed records and provided management information system guidance and technical assistance.

The complexities of operating the Pittsburgh/Allegheny County Healthy Start project requires competent and sufficient professional staff to perform essential functions such as fiscal and programmatic monitoring, health education, data collection, staff training, supervision, employee relations, community organizing and evaluation.

Healthy Start has proven its capability to hire key personnel, provide effective direct service to program participants, provide leadership in community collaborative efforts and to contract with relevant service providers and individuals in a timely and efficient manner.

The Executive Director coordinated operations, evaluation and programmatic initiatives and sustainability efforts, supervised and trained key personnel (10) and provided direction for all components of the Healthy Start grant. In addition, she worked in conjunction with the Board of Directors, the Evaluator and the Quality Improvement Committee and the Consortia Chairs and Vice Chairs.

The Controller provided fiscal oversight for all components of the project and oversees the audit, billings and budgets, manages the fiscal transactions for the organization and establishes vendor relationships. In the last seven years, there were no deficiencies or exceptions noted in the organization's annual audits, reviews and reports. The Executive Director supervised the Controller who in turn supervised the Senior Accountant, Payroll Specialist and Accounting Clerk.

Supervised by the Executive Director, the Clinical Coordinator, Program Administrator, the Licensed Social Worker and two Field Managers had responsibility for and supervised the Core Team operations.

The Healthy Start, Inc. Core Teams were composed of nurses (6), outreach workers (18), a MSW, a Training and Development Manager and a Male Program Manager, four Program Assistants and two Data Abstractors, an Operations Assistant, Information and Referral Specialist and a Receptionist/Sectary. Supervisors monitored Core Team activities, monitored home visits, reviewed and audited 50 charts monthly and prepared reports, as required, for the Healthy Start Board of Directors.

The Perinatal System Liaison, supervised by the Executive Director, had responsibility for the six Regional Consortia. Since the inception of the program, the Consortia have been and

continue to be the primary resource for legislative advocacy, education and ongoing community activities that were a benefit for the community.

The Evaluator is responsible for adapting best practices, coordination collection of quantitative and qualitative information regarding participants and measuring progress toward meeting project objectives. Participant Satisfaction was closely monitored through a Consumer/Participant Satisfaction Survey and A Baby Item Needs Assessment Survey. Both were conducted by the Graduate School of Public Health, University of Pittsburgh.

As the project grew, existing professional staff maintained current efforts and expanded into other areas such as services for male partners of case managed women, depression screening and referral, grantsmanship and development, specialty services for women suffering with perinatal addiction, teen pregnancy, marketing/public relations, sustainability and system management.

From June 1, 2000 through June 30, 2005, Healthy Start, Inc. contracted with an outside Management Information Systems firm to host our data. In 2005, Healthy Start, Inc. put out for bid and hired an outside vendor with non-profit experience to build a database.

In February 2005, an Information and Technology Liaison position was newly created within Healthy Start to provide technical assistance computer support. The first Data Analyst was hired in 2002 to assist with needs assessments and statistical reports.

Healthy Start participated in the Child Death Review and assisted in the formation and development of the Perinatal Periods of Risk (PPOR) process for Allegheny County. Team members consists of staff from the SIDS Alliance, the Allegheny County Health Department, the Allegheny County Coroner, the University of Pittsburgh's Graduate School of Public Health and the Center for Minority Health and Healthy Start, Inc. Members reviewed methodologies for collection of infant mortality data.

C.

In 1991, when the Health Department formed the non-profit Healthy Start, Inc., it was assumed that at some point in the future the non-profit Healthy Start, Inc. would stand alone as an entity separate and distinct from the Health Department, which was a unit of local government.

The decision by the Health Department to move from the role of actual grantee to one of collaborating partner providing technical expertise is evidence of Healthy Start, Inc.'s capacity to stand alone as a completely independent, private non-profit organization.

As part of the governance structure, it was determined, early on, that for the life of the Healthy Start initiative, the Director of the Allegheny County Health Department would have a seat on Healthy Start, Inc.'s Board of Directors.

Many challenges occurred in relation to project management. The Allegheny County Health Department staff composition changed during the reporting period. The retirement of the Title V Maternal Child Health Chief created a void within the Health Department system. The current acting Health Department Project Director shared duties and responsibilities of that position. In

addition, the Project experienced another loss when the Health Department Biostatistics Chief resigned her position. In 2004, the Health Department hired two Epidemiologists to fill this void.

The Project Director from 2002 through 2005, a Health Department employee, has served as an Ex-officio member on the Healthy Start, Inc., Board of Directors since the inception of the initiative in 1991. The 2005 grantee change eliminated the Project Director's position and her ex-officio Board role.

The original Project Director, a thirty year Allegheny County Health Department employee, resigned her position to accept a job with the Duval County Health Department in Jacksonville, Florida in January 2002. The Allegheny County Health Department Director appointed another Senior Health Department Staff person Interim Project Director. The Interim Project Director continued in this role until the grantee change in May 2005.

Healthy Start, Inc. has "matured". It has expanded its capacity in the areas of governance, administration and programmatic management. This "maturing" is most evidenced by the assumption of the role of grantee from the Allegheny County Health Department.

Minimal changes were made to the Healthy Start, Inc. Board of Directors. Wilford A. Payne, the Executive Director of a local Federally Qualified Health Center continues to serve as Chair and Dr. Robert L. Thompson, a prominent local Gynecologist serves as Vice Chair. All other officers remain the same and the incumbent community members were reelected. The Board held its annual retreat on April 29 and 30, 2004

On June 30, 2003, the Healthy Start, Inc. Board of Directors' accepted the resignation of the Executive Director. On July 1, 2003, the Board of Directors appointed the Fayette County Healthy Start Program Administrator as Interim Director. She continued in this capacity while the Healthy Start Board of Directors instituted a local and national search. And in February 2004, the Board of Directors made the interim appointment permanent.

Hired in 1997 for her administrative and data expertise, the Pittsburgh Program Administrator resigned on September 24, 2004 to accept an Executive Director position with the Pennsylvania Department of Health. She has been replaced by a Clinical Coordinator, a Bio-statistician/Data Analyst trained by Allegheny County Health Department personnel and an Information Technology Liaison.

After seven year's with Healthy Start, the Controller resigned her position in March 2005. The Assistant Controller applied for the position and continues in the role as "Acting" Controller.

The myriad needs of indigenous staff had the organization redesigning the Human Resource position to make room for a Benefits Specialist and Compliance Officer.

D.
The original fund distribution process developed and implemented in 1991 remained in place until April 1, 2005. At that time, the Allegheny County Health Department succeeded the grantee role to the non-profit Healthy Start.

The Health Department had the overall responsibility for the financial management of the grant and the non-profit had responsibility for the day-to-day fiscal operations. The six Regional Consortia advised on fiscal decisions for their communities and the Healthy Start, Inc. Board of Directors approved the overall budget.

Invoices were reviewed by Healthy Start, Inc. program and fiscal staff prior to payment. The nonprofit received funds on a reimbursement system with the Health Department.

Completed time sheets were maintained for all staff. The Time Sheet reflected any time way from the office such as vacation, sick leave, personal and permission time (travel, training, etc.). These were reviewed and approved by the appropriate supervisor and were audited by the Controller on a monthly basis.

An inventory of all assets purchased under the grant, since inception (October 1, 1992), was prepared by the Accounting Clerk and reviewed by the Board of Directors Finance Committee.

The Allegheny County Health Department Deputy Director, Administration provided fiscal oversight for all components of the project. Additional responsibilities included the yearly audits, billings to the county and budgets.

The composition of the Fiscal Department has changed according to the organizational needs. For the majority of this reporting period, Healthy Start's Fiscal Department consisted of a Controller, Senior Accountant, Payroll Specialist and Accounting Clerk. The staff had overall responsibility for and directed the procurement and budgeting functions for the non-profit. They reviewed payment to providers to insure compliance and prepared accounts payable and receivables and payroll and managed financial transactions, established vendor relationships, coordinated audits and monitored contracted fiscal management.

The Healthy Start, Inc. check signing process, instituted in 1992 by the Board of Directors, stipulates that any check in excess of $200 requires two signatures. Checks, totaling two hundred dollars or more, must be signed by the non-profit Executive Director or the Controller and the Board Treasurer and Chair of the Finance Committee or another member of the Board Executive Committee. The Board Executive Committee is comprised of the Chair, Vice Chair, Secretary and Treasurer.

E.
The use of contracted services became necessary when services generally provided by the grantee agency, the Allegheny County Health Department ceased. For example, when the Health Department's Management Information System Administrator and the Chief of Bio-statistic resigned their positions Healthy Start contracted with outside vendors until appropriate staff was identified.

F.

It is a fundamental principle of Healthy Start, Inc., that all services, program components, media campaigns, literature (flyers, posters, pamphlets and brochures) and vendors be culturally and linguistically appropriate and that sensitivity and diversity be maintained at all time.

IV. Project Accomplishments

Outreach and Client Recruitment

Project Period Objective	Strategies and Activities	Responsible Staff/Partnerships	Accomplishments
By 5/31/2005,outreach and recruitment 2,175 pregnant women (at least 85% African American) residing primarily in the project area and pregnant women identified as high risk throughout Allegheny County into Healthy Start case management services. Baseline: 1,028 pregnant women residing in the project area received case management services 88%(907) of these women were African American) --- By 5/31/2005, outreach and recruit 1,015 infants under one residing primarily in the project area and identified in the project area and identified throughout Allegheny County into case management services Baseline: 1,276 infants residing in the project area and high risk infants in Allegheny County received case management services. 89% (1,133) of these infants were African American (case management records 1998)	Strategies for Mother & Infant Objectives: -- Aggressive community outreach and expansion county wide for high-risk women and infants. 1) Contacted 5,000 women of childbearing age (10-44) targeting African American women in the project area to provide information and education regarding the need for early prenatal care. 2) O.E.A staff utilized vans and travel throughout project area and county to provide information regarding need for early and regular prenatal care. 3) Assured 48 hours assessment for 95% of participants through the Helpline and O.E.A Team	Helpline Information and Referral Specialist, O.E.A Team, Male Initiative Program (MIP) Outreach Workers, Registered Nurses, Field Managers, Clinical Coordinator, Perinatal System Liaison Collaborations with local health and human service providers, i.e., Family Support Centers, Family Childhood Initiative, Early Head Start, physicians, hospital clinics, schools & businesses	As of May 31, 2005, 4259 Pregnant women were enrolled 3613 (85 % were African American) (MIS 2004) As of May 31, 2005, 1094 Postpartum women were enrolled – 841(77 % were African American) (MIS 2004) A total of 5353 of pregnant and postpartum women were cased managed this period- 83% (4454) were African American (MIS 2004) 47,532 women of childbearing age received enrollment information, referral services and breastfeeding referrals through the Helpline 19,861 families received flyers, pamphlets and door knockers during community canvassing 1390 age appropriate health screening schedules disturbed to community/program participants, local business, health and human services --- As of 5/31/05: 1712 new infants were enrolled 1557 (91 % were African American) and 4859 infants were case managed – 4027 (83 % were African American) (MIS 2004)

Project Period Objective	Strategies and Activities	Responsible Staff/Partnerships	Accomplishments
By 5/31/2005, outreach and recruit 955 spouses/male partners into case management services. Baseline: 225 male partners received case management services, MIP case management records 1998.	1) Engage 1000 male partners of women being case managed in the Healthy Start program. 2) Engage fathers during sporting events, barbershops, fathers programs, etc. 3) O.E.A staff will utilize vans and travel throughout project area and county to provide information regarding need for early and regular prenatal care. 4) Assure 48 hours assessment for 95% of participants through the Helpline and O.E.A Team	All the HS Staff listed above Collaborations: The Fathers Collaborative, The University of Pittsburgh, Office of Child Development, Goodwill, Greater Pittsburgh Fatherhood Initiative and Family Division-Domestic Relations Service, Single and Custodial Fathers Network, Pittsburgh Board of Education Collaborations: The Fathers Collaborative, a partnership with the University of Pittsburgh, Office of Child Development, Goodwill, Greater Pittsburgh Fatherhood Initiative and Family Division-Domestic Relations Service, Single and Custodial Fathers Network (SCFN), Pittsburgh Board of Education Liaison	As of May 31, 2005, 447 men were case management – 420 (94% were African American)

Challenges	Strategies and Activities	Partnerships	Outcomes

Changing Demographics & Unstable Housing	Alternate contact information received from all participants (ongoing) Inform clients of affordable & safe housing	Housing Authority of Allegheny County, Housing Urban Development, Urban League, Section 8 Housing, Bridge Housing, Debra House, Allegheny Rehabilitation Corp, Fair Housing Partnership, Roselia Center, Sister Place, Benedictine Place, Healthy Start House	2001-2004: 12 % of all case managed participants self-reported unstable housing situations
Educational Opportunities & Welfare Reform Effects	Home visits are scheduled to address the time constraints of program participants Referrals are made to GED programs that meet a variety of client schedules Healthy Start workshops offered on interviewing skills	Urban League, Providence Family Support, Community College of Allegheny County,	2001-2004: 73% of all case managed participants were in enrolled in Department of Welfare Medicaid/HMO Programs 2001-2004: 1.2% of all case managed participants' self-reported need for educational assistance.
Health Care Under-utilization	Inform clients of Health Care Providers who are sensitive to the beliefs and values of program participants, flexible in scheduling & sensitivity to time constraints	Federally Qualified Health Centers, Hospitals/Physicians, Managed Care Organizations, community Based Health Centers	2001-2004: 17% of all case managed participants lacked health insurance upon enrollment for HSI services 2001-2004: 2.8% of all infants required assistance with obtaining medical insurance
Lack of Childcare	Child Care referrals & provisions	Childcare Partnerships, Area Child Care Centers, YWCA	2001-2004: 36% of all case managed participants were employed and/or attended school
Lack of Trust	<u>Home Visiting/Case Management</u> Minimum 15 home visits (averaging 1 hour) completed weekly The Team diversity that reflects the demographics of each community including hires within the community Conduct program participant surveys and focus groups for input to develop core plan reflecting wants & needs	Healthy Start Multidisciplinary Team, Consortia, HSI Board of Directors, Area Churches, Schools	2001-2004: 40,000 Home visits completed based on number individual field staff members x 15 home visits weekly= 10,000 per year rate

Challenges	Strategies and Activities	Partnerships	Outcomes
Depression & Other Mental Health	Screenings are conducted on a regular basis with all program participants	Western Psychiatric Institute Center, Mercy Behavior, Magee Women Behavior Health,	2001-2004: 13% of all new case managed participants self reported

Depression & Other Mental Health Problems	Screenings are conducted on a regular basis with all program participants Referrals are given to appropriate collaborating agencies and printed information is provided Phone calls, scheduling appointments, etc. provided by HS Team upon request	Western Psychiatric Institute Center, Mercy Behavior, Magee Women Behavior Health, Contact Pittsburgh, Mon-Yough, Catholic Charities, Allegheny County office of Behavioral Health, Family Services of Western PA	2001-2004: 13% of all new case managed participants self reported having difficulties with depression and/or other mental health problems
Domestic Violence	Provide referrals to safe houses & women's shelters Emergency hotline proved at Healthy start & other alternative agencies Create a safety plan	Women Center & Shelter, Alle-Kiski Hope Center, Bethlehem Haven of Pittsburgh, Womanspace East, Womensplace Inc. , Crisis Center North, Jewish Family and Children's Services, Center for Victims of Violent Crimes, Pittsburgh Action Against Rape, East Suburban Task Force	2001-2004: 5.2% of all new case managed participants self reported being involved in domestic violence situations
Substance Abuse	<u>Health Education</u> Substance Abuse & Prevention services offered through HS in-home services & group settings Referrals made to D&A Centers Provide ongoing prevention education those not ready for assessment/treatment	Mon-Yough, Operation Nehemiah, St. Francis Perinatal Addictions Center, Turtle Creek Valley, Zoar New day, Addison Terrance, Alpha House, Spectrum Family Network, Gateway Rehabilitation Centers, Abraxas, TADISCO, House of the Crossroads, Mercy Behavioral Health, P.O.W.E.R., Project Recovery, Family Links, Addison Terrance, Myriams, Cove Forge, Braddock Hospital Detox, Green	2001-2004: 16 % of all case managed participants self-reported usage of alcohol, tobacco and other drugs

Case Management

Depression & Other Mental Health Problems	Screenings are conducted on a regular basis with all program participants Referrals are given to appropriate collaborating agencies and printed information is provided Phone calls, scheduling appointments, etc. provided by HS Team upon request	Western Psychiatric Institute Center, Mercy Behavior, Magee Women Behavior Health, Contact Pittsburgh, Mon-Yough, Catholic Charities, Allegheny County office of Behavioral Health, Family Services of Western PA	2001-2004: 13% of all new case managed participants self reported having difficulties with depression and/or other mental health problems
Domestic Violence	Provide referrals to safe houses & women's shelters Emergency hotline proved at Healthy start & other alternative agencies Create a safety plan	Women Center & Shelter, Alle-Kiski Hope Center, Bethlehem Haven of Pittsburgh, Womanspace East, Womensplace Inc. , Crisis Center North, Jewish Family and Children's Services, Center for Victims of Violent Crimes, Pittsburgh Action Against Rape, East Suburban Task Force	2001-2004: 5.2% of all new case managed participants self reported being involved in domestic violence situations
Substance Abuse	<u>Health Education</u> Substance Abuse & Prevention services offered through HS in-home services & group settings Referrals made to D&A Centers Provide ongoing prevention education	Mon-Yough, Operation Nehemiah, St. Francis Perinatal Addictions Center, Turtle Creek Valley, Zoar New day, Addison Terrance, Alpha House, Spectrum Family Network, Gateway Rehabilitation Centers, Abraxas, TADISCO, House of the Crossroads, Mercy Behavioral Health, [illegible]	2001-2004: 16 % of all case managed participants self-reported usage of alcohol, tobacco and other drugs

Case Management

Domestic Violence	Provide referrals to safe houses & women's shelters Emergency hotline proved at Healthy start & other alternative agencies Create a safety plan	Women Center & Shelter, Alle-Kiski Hope Center, Bethlehem Haven of Pittsburgh, Womanspace East, Womensplace Inc. , Crisis Center North, Jewish Family and Children's Services, Center for Victims of Violent Crimes, Pittsburgh Action Against Rape, East Suburban Task Force	2001-2004: 5.2% of all new case managed participants self reported being involved in domestic violence situations

Substance Abuse	Health Education Substance Abuse & Prevention services offered through HS in-home services & group settings Referrals made to D&A Centers Provide ongoing prevention education those not ready for assessment/treatment	Mon-Yough, Operation Nehemiah, St. Francis Perinatal Addictions Center, Turtle Creek Valley, Zoar New day, Addison Terrance, Alpha House, Spectrum Family Network, Gateway Rehabilitation Centers, Abraxas, TADISCO, House of the Crossroads, Mercy Behavioral Health, P.O.W.E.R., Project Recovery, Family Links, Addison Terrance, Myriams, Cove Forge, Braddock Hospital Detox, Green briar Treatment Center, Discovery House, Western Psychiatric Institute and Clinic (WPIC), STRENGTH,Inc.	2001-2004: 16 % of all case managed participants self-reported usage of alcohol, tobacco and other drugs

Case Management

Project Period Objective	Strategy and Activities	Accomplishments
By 6/1/05, increase to 85% the proportion of African American pregnant women who begin care in the first trimester of pregnancy. (Baseline: 75.7% of pregnant women who enrolled in case management initiated prenatal care in the first trimester (Case Management Records and ACHD Birth Certificates)	Strategy: Targeted outreach and recruitment, Health Education, Case Management Activities: 1. Neighborhood Canvassing (ongoing) 2. Attended Community Events (ongoing) 3. Administrative staff met/corresponded with health and human service providers regarding the provision of care to individuals and families in the project area (ongoing). 4. Provided referrals and follow-up for 100% of those women in the 1st trimester not receiving prenatal care (ongoing) 5. Identified and enrolled high risk African American women county-wide through hospital, private physician, community-based provider referrals (ongoing). 6. Provided educational campaigns about early prenatal care using a	Year 1 Progress: 84.5% Year 2 Progress: 82% Year 3 Progress: 81.6% Year 4 Progress: 83.8% 1. Completed 2. Completed as available 3. Completed 4. Completed at 100% 5. Completed 6. Completed

	variety of mediums and markets (ongoing).	
By 6/1/05, no more than 11% of the African American infants born will weigh less than 2,500 grams. (Baseline: 14.4% of infants born to case managed women who prenatally received services weighed less than 2,500 grams. Case Management Records, 1998) --- By 6/1/05, no more than 1.5% of the African American infants born will weigh less than 1,500 grams. (Baseline: 2.0% of infants born to case managed women who prenatally received services weighed less than 1,500 grams. Case Management Records, 1998)	Strategies for both Objectives: Case Management, Health Education, Referral & Monitoring, Early intervention/prevention/ identification and linkage Activities: 1. Identified pregnant African American women for 1st and 2nd trimester enrollment (ongoing). 2. RNs provided Clean Air for Healthy Children smoking cessation assessment and intervention for 100% of pregnant women who smoke. 3. Provided nutritional and breast feeding education to all enrolled women (ongoing). 4. Referred 100% of women to WIC if not enrolled (ongoing). 5. Staff training on LBW, VLBW, preterm labor, etc. (ongoing). 6. Provided intensive case management for 100% of substance-abusing women enrolled in Healthy Start (June 2003 – present) 7. Developed a plan of care with participants and in conjunction with spouses and partners (ongoing).	Year 1 Progress: 15.3% Year 2 Progress: 14.4% Year 3 Progress: 13.8% Year 4 Progress: 13.7% --- For both objectives: 1. Completed 2. Training and Implementation Completed 3. Completed at enrollment and during subsequent home visits. 4. Completed 5. Completed (yearly) and at new hire orientation 6. Completed via specialty team. 7. Completed --- Year 1 Progress: 5.1% Year 2 Progress: 4.5% Year 3 Progress: 4.2% Year 4 Progress: 4.2%

Project Period Objective	Strategy and Activities	Accomplishments
By 6/1/05, no more than 15% of births to mothers who prenatally enrolled into case management services will occur within 24 months of a previous birth. (Baseline: 20% of pregnant women and a previous birth occurring within 24 months. Case Management Records, 2000)	Strategy: Case Management, Health Education, Increase Postpartum check-up rates Activities: 1. Provided education to 100% of parents concerning methods of birth control and benefits of birth spacing (ongoing). 2. Distributed brochures relevant to family planning (ongoing). 3. Educated on and assisted with scheduling postpartum check-ups to discuss birth control after delivery (ongoing). 4. Developed a plan of care with participants and in conjunction with spouses and partners (ongoing). 5. Educated staff on birth spacing/family planning options (ongoing).	Year 1 Progress: 15.0% Year 2 Progress: 14.5% Year 3 Progress: 14.2% Year 4 Progress: 14.0% 1. Completed 2. Completed 3. Completed 4. Completed for all participants 5. Completed yearly
By 6/1/05 70% of referrals for pregnant women will be completed. (Baseline: 62% of referrals were completed for pregnant women. Case	Strategies for Both Objectives: Case Management, Referral & Monitoring, Database Management, Early Identification, Risk Assessments Activities: 1. Identified risks and developed plan of cares for all pregnant women and infants (ongoing).	Year 1 Progress: 43.0% Year 2 Progress: 76.0% Year 3 Progress: 98.7% Year 4 Progress: 95.6% --- For both objectives:

Management Records, 1998). --- By 6/1/05, 75% of referrals for infants will be completed. (Baseline: 62% of referrals were completed for infants, Case Management Records, 1998).	2. Quality Assurance on all charts and databases to ensure that referrals were completed (quarterly). 3. Appropriate referrals and tracking were made for indicated risks relating to: medical care, health insurance, WIC, behavioral health, etc (ongoing). 4. Provided transportation assistance to attend all appointments (ongoing).	1. Completed 2. Completed at least Quarterly 3. Completed as Needed 4. Completed as Needed --- Year 1 Progress:50.0 % Year 2 Progress: 80.0% Year 3 Progress: 91.6% Year 4 Progress: 83.3%
By 6/1/05, 100% of all CSHCN have appropriate medical and ancillary care services. (Baseline: An estimated 50 infants had special health care needs in 2000, Case Management Records)	Strategy: Case Management, Healthy education Activities: 1. Assured that 100% of infants and children have primary care provider/ medical home (ongoing). 2. Coordinated and monitored care with health care providers (ongoing). 3. RN conducted developmental assessments using either the Ages and Stages or Denver Developmental tools (ongoing). 4. Referral and linkages to community resources specializing in CSHCN (ongoing). 5. Trained staff on child development and indicators of developmental difficulties (ongoing).	Year 1 Progress: 100% Year 2 Progress: 100% Year 3 Progress: 100% Year 4 Progress: 100% 1. Completed 2. Completed 3. Completed on all infants and children up to the age of 2 years. 4. Completed as required 5. Completed yearly.

Accomplishments/ Highlights

Healthy Start Inc. has successfully replicated its model of case management to meet the needs of targeted program and community participants both within and outside the project areas. Most notably, services were expanded into five (5) additional service areas within Allegheny County most at need of perinatal intervention/prevention. Through a three-year, $300,000 grant awarded by the Heinz Endowments, over 500 women, men and children have received case management with the impact being a lower rate of infant mortality, low weight births and improved access to care. Healthy Start Inc. has replicated case management in two other outside agencies with similar effectiveness in the Resource Mother's and the Nurse Family Partnership Programs through collaboration with the local Title V group.

The effectiveness of this model is respected not only in the local sector, but nationally and within the National Healthy Start Association. As national leaders Healthy Start Inc. has mentored Healthy Start projects across the country and provided evaluation and feedback to assure that the product meets the need in their communities, both urban and rural. The chart below provides a sample of presentations regularly delivered by Healthy Start, Inc. staff nationally and locally.

Healthy Start Pittsburgh/Allegheny Best Practice Presentations

Topic	Title	Audience	Location
Core Service Models	"Pittsburgh/Allegheny County Healthy Start Service Systems Model"	The Pittsburgh International Visitors Bureau – Russian Professional Guests of the University of Pittsburgh	Pittsburgh, PA
Managed Care Reimbursement	"Seeking Reimbursement"	Pennsylvania Perinatal Partnership (PPP), Title V, PA Department of Health	Harrisburg, PA
Managed Care Reimbursement	"Seeking Reimbursement"	National Healthy Start Grantees	Washington, D.C.
Eliminating Health Disparities	"Eliminating Child Health Disparities by a Partnership of Parents, Neighbors and Communities: The Pittsburgh Allegheny County Healthy Start Model"	Institute for Family-Centered Care	San Francisco, CA
Case Management	"Case Management Models that Work: From Rural to Urban Areas"	Health Resources and Services Administration (HRSA), National Healthy Start Grantee Meeting	Washington, D.C.
Specialty Case Management	"Alcohol, Tobacco and Other Drugs (ATOD): Preconceptional Health: ATOD Before and After Pregnancy"	HRSA, NHSA	Washington, D.C.
Developing a Perinatal Service System	"Building a Comprehensive Service System for Rural Appalachian African-American Women and Their Families"	National Minority Rural Health Conference	New Orleans, LA

Topic	Title	Audience	Location
Model of Community & School Based Collaboration on Fatherhood Involvement and Case Management	"Foundation for positive Male and Father Involvement to Empower Families"	National Head Start Association, Head Start Administrators, Directors, Teachers, Parents, and Volunteers	Dallas, TX.
Best Practices Model	"Engaging Communities and Consumers in the Health Planning Process"	Interactive TV Workshop at sites throughout PA, OH, MD, WV, and NJ	University of Pittsburgh
Women's Perinatal Health	"Perinatal Periods of Risk: Promising Practices"	Expedition 2004: City Match Conference	Portland, OR
Designing and Implementing Effective Practices	"The Healthy Start Guide to Program Excellence"	NHSA's Regional Conference: East National	Morgantown, West Virginia

Case Management Accomplishment Highlights 2003	Baseline 1996-2000	Year 2003 Impact
Increase the proportion of African American pregnant women in the Project Area who receive prenatal care in the first trimester.	76%	86.5%
Increase the number of parenting teens who have selected a method of birth control after delivery.	66%	87.6%
Reduce the incidence of poor birth spacing.	20%	11%
Assure that all children with special health care needs (CSHCN) have appropriate medical and ancillary care needs available to them.	69%	100%
Screen 600 pregnant and postpartum women for perinatal depression.	108	859

Male Initiative Program (MIP) Impact/ Accomplishments

A unique and effective approach to increasing male involvement has been the Family Focus Night groups held on a monthly basis. These groups are open to males and the spouses with the purpose is to provide education on a variety of social and health topics. The group also serves as an informal mentoring and support network for new fathers or those that may be experiencing relationship difficulties. Evaluations from these events have indicated the highest participant satisfaction. Greater than 200 fathers and 150 women have attending these sessions over the past four years.

Healthy Start has initiated several prevention programs aimed at decreasing incidences in the areas of teen parenting, poor birth spacing, substance abuse, and low weight births. Most notably, through the efforts of the MIP program and in collaboration with the Core Team, 6107 elementary, middle and high school students have been served at 23 schools in Pittsburgh Public School District via classroom presentations, special events, and individual support conferences.

Teacher evaluations indicate success in areas outside of pregnancy and parenthood. One particular classroom teacher evaluated her students and noted that 82% of students should improvement in classroom work, 82% were more attentive in class, 90% showed improved grades and overall, 82% (9 of 11) students improved academically. Students' behavior changes in class were improved significantly as well. The teacher identified that 55% showed improvement by controlling anger in class and 45% displayed improved sign of respecting self and classmates.

The following general programmatic strategies are utilized by Healthy Start Inc. to address female and male participant barriers to service:

- Employed indigenous paraprofessional workers.
- Provided services at the participant's home to reduce loss of care due to access problems
- Established linkages with a broad array of community-based health and human service providers in the targeted areas.
- Enhanced referral networks and collaborations with service provider linkages.
- Employed two (2) social workers (BSW and LSW) to meet the mental health needs of participants.
- Provided intensive case management for pregnant or parenting teens and pregnant or parenting substance abusers.
- Targeted fathers, husbands, and significant others of female participants and provides intensive case management.
- Facilitated transportation and child care (Healthy Start, Inc. vans, bus tickets, etc.)
- Monitored attendance of medical/behavioral health appointments.
- Trained program staff, regional consortia members, program and community participants, as well as other program/agency providers on issued related to maternal and child health.
- Obtained health care insurance (i.e., assisted with identifying carriers of service and completing health insurance applications)
- Identified available and affordable health care providers (i.e., hospital clinics, community-based or federally-funded health centers)
- Referred and monitored referrals to assess levels of compliance.
- Developed strategic plans to assist participants with reception of care. This included overcoming social, emotional, and cultural barriers preventing care.
- Coordinated transportation services (i.e., distributed bus tickets, transported participants using Healthy Start vans to needed medical appointments, etc.)
- Provided childcare services during Healthy Start group activities, referrals and follow-ups to the Child Care Partnership program, and assisted participants with utilizing appropriate family or community supports for child care needs.

Health Education

Project Period Objective	Strategies and Activities	Responsible Staff/Partnerships	Accomplishments
By 5/31/05, increase participant knowledge of perinatal risks related to smoking Baseline: 26% (156 of 608) of participating women reported tobacco use while pregnant (ACHD Birth Certificates 1998-1999 representative sample).	1. Provided annual in-service trainings for all field staff; keeping them abreast of risks associated with smoking; ensuring that field staff may relay correct and up-to-date information to program participants. 2. Continued education of the perinatal risks of smoking was reinforced throughout the case management process. The total number of case managed women. 3. Pregnant women were assessed and monitored throughout pregnancy during their case management visits. 4. All pregnant women who were ready to quit were referred to smoking cessation programs by their outreach worker. 5. All pregnant women and postpartum women identified to smoke were educated and introduced to PA Clean Air for Healthy Children Program; readiness to quit/reduce smoking will be assessed before entrance into the program 6. Fact sheets and educational brochures about the dangers of perinatal smoking were distributed to all participants. 7.PA Clean Air materials were circulated to all pregnant, postpartum women and their partners	Healthy Start Staff: RNs, Outreach Workers, MIP Staff, Field Managers, Collaborators: Health and Human Service Providers, Consortia, Healthy Hearts & Souls, MCO Special Needs Units	1. 100% of field staff (RNs, Outreach Workers, and LSWs) were provided annual in-service trainings updating them to the risks of smoking perinatally; totaling 8 hours of training and educating 109 staff members 2. 100% (4304 of 4304) of program participants have been educated to the dangers of perinatal use of tobacco. 3. 100% (1009 0f 1009) pregnant women received assessments and monitoring throughout pregnancy 4. 100% (1009 of 1009) pregnant women who smoke have received training and education on smoking risks. 5. 23.44% (1009 of 4304) of pregnant women in 2004 reported smoking during pregnancy 6. 100% (4304 of 4304) of program participants received educational brochures 7. 100% (4414 of 4414) of pregnant, postpartum women and their partners received PA Clean Air materials

Project Period Objective	Strategies and Activities	Responsible Staff/Partnerships	Accomplishments
By 5/31/05, increase knowledge of Healthy Start staff related to HIV/AIDS and perinatal health disparities through training and education Baseline:121 females between ages 10-39 had been diagnosed with AIDS in Allegheny County for 1981 – 1999 (ACHD STD Report 1999)	1. Provide annual in-service training on HIV/AIDS for all staff on PA laws, confidentiality, HIV transmission and risk behaviors community resources, there were a total of 9 trainings on HIV/AIDS. 2. Provide training to all new staff on HIV/AIDS	Healthy Start Staff: Training and Development Coordinator, Health Educator, and Program Administrator Collaborators: PA Mid-Atlantic, Allegheny County Health Department (ACHD) STDs/HIV/AIDS Program, Pittsburgh AIDS Task Force, Minority HIV/AIDS Working Group, The Pittsburgh AIDS Center for Treatment - UPMC	1. 100% of Healthy Start Staff received HIV/AIDS and perinatal health disparities training and education. Staff has received a total of 24 hours of HIV training 2. All staff was provided current and up-to-date HIV/AIDS information

Challenges	Strategies and Activities	Partnerships	Outcomes
Transportation	1.Provide Bus tickets 2. Provide Van transportation 3. Provide health education and trainings in the community so that they are more easily accessible	Healthy Start Staff	9286 participants were provided health education from 2001 to 2005
Cultural insensitivity of health & human service systems, as well as, presenters who are culturally competent	1.Collaborative educational trainings for healthcare providers and Healthy Start staff allowing for a venue of multiple vantage points 2. Staff are provided annual trainings on cultural sensitivity	Healthy Start Staff, Allegheny County Health Department, WIC, Family Links, University of Pittsburgh,	4 trainings on cultural competency 203 staff were trained in cultural competency and attended 11 hours of training
Awareness of resources	1. Provided Staff and participant trainings on how to navigate the healthcare system. 2. Through collaboration and networking healthy start maintains alliances with many organizations which keep us up-to-date with changes in the healthcare fields.	Healthy Start Staff, Allegheny County Health Department, Western Pennsylvania Institute and Clinic, West Penn Hospital, Healthy Hearts & Souls, Family Links, Gateway Rehabilitation Center, SIDS Alliance of PA, Community Connections for Families	100 trainings which outlined resources our participants can utilize
Reaching high risk participants	1. Healthy Start is able to reach high risk participants through educational activities in the community such as; focus groups, educational canvassing, baby showers and health fairs 2. Case management in the home	Healthy Start Staff	6 annual baby showers reached 1,200 participants 6 annual health fairs reached 2,000 community, Consortia, and program participants
Childcare	1. Provide health education and trainings at times when children are at school or daycare 2. Provide childcare at the trainings free of charge so mothers can participate in the educational activity or reimbursement for at home childcare services	Healthy Start Staff	35 trainings events where childcare was provided to XX families

Interconceptional Care

Project Period Objective	Strategies and Activities	Responsible Staff/Partnerships	Accomplishments
By 5/31/2005, Increase to 90% the percentage who have received age appropriate immunizations Baseline: 86% of infants were age appropriately immunized by age one(case management records 1998-2000 average)	Strategy: Interconceptional Care, Outreach and Recruitment, Case Management and Health Education Activities and Timeframe: 1. Home Visits- As Referred, Ongoing 2. Immunization Schedules(written materials, magnets, tracking sheets- Ongoing 3. Participation in National Immunization Campaigns- Yearly 4. Helpline – Ongoing 5. Telephone Vignettes- Ongoing 6. Transportation and Childcare – Ongoing 7. Database Management – Ongoing 8. Immunization training to all staff and Consortia members-	Responsible Staff: MDT, OEA, Health Educator, Information and Referral Specialist (IR), Operations Assistant, Data Analyst, Health Educator, Clinical Coordinator Collaborating Partners: Allegheny County Health Department, Magee Women's Hospital, Children's Hospital of Pittsburgh, Federally Qualified Health Centers, Local Health Providers	90% (513/564) of infants, two years of age received appropriate immunizations. 100% of infants had primary pediatric providers
By 5/31/2005, Increase to at least 75% participating postpartum women who receive interconceptional(family planning) services from a medical provider Baseline: 51.7% (501 of 969) of postpartum women received interconceptional services during the reporting period (case	Strategy: Interconceptional Care, Case Management and Health Education Activities and Timeframe: 1. Home Visits- Ongoing through child's 2nd birthday 2. Referral and Monitoring- Ongoing 3. Establishing a medical home- At enrollment and ongoing 4. Case Review/Case Conference - Weekly 5. Maintaining Relationships with and educating local medical and health providers - Ongoing 6. Advocacy – Ongoing 7. Transportation and Childcare – Ongoing 8. Database Management- Ongoing	Responsible Staff: MDT, OEA, Health Educator, IR, Operations Assistant, Data Analyst, Health Educator, Clinical Coordinator Collaborating Providers: Federally Qualified Health Centers, Family Health Council, Planned Parenthood of Western Pa, Primary Care physicians, specialist, local area hospitals	74.90% (604/806) postpartum women received interconceptional services from a medical provider.
By 5/31/2005, Increase to 80% the percentage of parenting teens who have selected a method of contraception after delivery Baseline: 66% (241 of 365) of teens selected a method of contraception after delivery during the	Strategy: Interconceptional Care Case Management and Health Education Activities and Timeframe: 1. Specialized case management – Ongoing 2. Home visits – Ongoing 3. Risk Assessments (prenatal/postpartum)- Every six months 4. Referral and monitoring ongoing 5. Case Reviews/Case Conferences- Weekly 6. Establishing a Medical Home- At enrollment and ongoing 7. Transportation and Childcare – Ongoing 8. Database Management - Ongoing	Responsible Staff: MDT, OEA, Health Educator, IR, Operations Assistant, Data Analyst, Health Educator, Clinical Coordinator Collaborating Partners: Federally Qualified Health Centers, Family Health Council, Planned Parenthood of Western Pa, Primary Care physicians, Specialists, Local Area Hospitals	Of the 61 sexually active teen program participants, (18 years or younger) 57 or 93.4% selected a method of contraception after delivery

Challenges	Strategies and Activities	Partnerships	Outcomes
Participant Barriers 1. lack of knowledge and skepticism about the effectiveness of prevention 2. inadequate or inappropriate utilization of health care services 3. poverty/low socioeconomic status.	1. Provide continual health education on the importance of having a medical home. 2. Monitor for receipt of health care services and we provide, assist with transportation and childcare 3. Assess participants' financial eligibility (Such as Medicaid or Title X eligibility) and assist them in navigating through the application process.	Federally Qualified Health Centers, Family Health Council, Planned Parenthood of Western Pa, Primary Care physicians, Specialists, Local Area Hospitals, Department of Public Welfare, WIC, Family Support Centers	Overall Health Education 2001: 9703 Participants 2002: 9083 Participants 2003: 580 Participants 2004: 7391 Participants Youth Education 2001: 1572 Participants 2002: 1513 Participants 2003: 1808 Participants 2004: 1122 Participants Family Education 2001: 2410 Participants 2002: 2160 Participants 2003: 976 Participants 2004: 1127 Participants
Provider Barriers 1. Lack of culturally competent and diverse staff 2. Lack of training in patient prevention counseling 3. Lack of follow-up for individuals and families in addressing health care needs 4. Lack of knowledge about and linkage to community-based health and human services	1. Act as an advocate for the individuals and families involved. 2. Accompany participants on visits to health care providers 3. Follow-up on participants' concerns of biased treatment. 4. Provide education to community providers via presentations on HSI services 5.Inviting them on site visits and providing opportunities for them to shadow outreach and nursing staff on participant visits	Federally Qualified Health Centers, Family Health Council, Planned Parenthood of Western Pa, Primary Care physicians, Specialists, Local Area Hospitals, Department of Public Welfare, WIC, Family Support Centers	Total Number of Provider Trainings Offered 2001: 147 Provider Trainings 2002: 162 Provider Trainings 2003: 150 Provider Trainings 2004: 32 Provider Trainings

Challenges	Strategies and Activities	Partnerships	Outcomes
System Barriers 1. Fragmentation of health and human services 2. Lack of coverage or inadequate reimbursement for services 3. Lack of adequate public transportation 4. Inadequate health and human services resources within a community.	1. Participating./Partnering with various organizations to eliminate existing health disparities to promote more continuity of care 2. Assisted with transportation and childcare 3.Advocated for the establishment of primary health care centers in underserved Healthy Start communities through creation of partnerships between the private health care providers	Federally Qualified Health Centers, Family Health Council, Planned Parenthood of Western Pa, Primary Care physicians, Specialists, Local Area Hospitals, Department of Public Welfare, WIC, Family Support Centers Pennsylvania Perinatal Partnerships Local Medicaid/Medicare Providers Behavioral Health Providers	Women in a medical home with an ongoing primary care provider 2001: 2313/3889=59.4% 2002: 1938/3038=63.7% 2003: 1671/2959=56.5% 2004: 1148/2180=52.6% Transportation services provided by Healthy Start 2001: 635 Participants 2002: 562 Participants 2003: 459 Participants 2004: 459 Participants

Depression Screening and Referral

Project Period Objective	Strategies and Activities	Responsible Staff/Partnerships	Accomplishments
By 5/31/2005, screen a total accumulation (for all years) of 3,190 pregnant and postpartum women for perinatal depression. Of those screened 110 (11%) will receive enhanced case management services including assessment and referral to mental health counseling/treatment providers.	1.RN's screened participants for postpartum depression 2.RN's made referrals to local mental health providers or the Healthy Start licensed social worker (LSW) 3. Outreach workers made referrals to LSW based on conversations with participants during home visits. 4. Social worker referral prompts LSW to call participant to schedule home visit.	Outreach workers, RN's, licensed social worker, local mental health providers, Western Psychiatric Institute and Clinic	1691 screenings were conducted. Of those screened, 209 (12%) received enhanced case management services. 133 participants were receiving medication and/or counseling services. From Feb. '04 –May '05, 76 participants accepted social worker referrals. Social worker made 104 home visits.

Challenges	Strategies and Activities	Partnerships	Outcomes
Licensed social worker (LSW) was hired in Feb. 2002 but left shortly thereafter, impeding the development of the depression component.	1. Continued search for LSW 2. In lieu of having a social worker to conduct screenings, RN's screened participants for depression with Beck Depression Inventory, and later with the Edinburgh Postnatal Depression Scale in Sept. 2002. (A total of 610 participants were screened in 2001 and 2002)	University of Pittsburgh School of Social Work, Western Psychiatric Institute and Clinic	1. LSW hired in Nov. 2003 2. Protocol for screening developed 3. Further assessments made as a result of social worker referrals 4. Social worker available for consultation and home visits on high risk cases
Participants encounter lengthy waiting period for mental health services due to lack of providers	1. Licensed social worker (LSW) conducted in-home therapy until participants are able to enter mental health care system. 2. Referral of participants to the Western Psychiatric Institute and Clinic (WPIC) for services through their depression studies. 3. Conducted presentation for doctors during their site visits of Healthy Start which included home visits with participants	Western Psychiatric Institute and Clinic, Univ. of Pittsburgh Medical Center, Pa. Area Health Education Center	1. Participants' issues are addressed at the time they are most willing to deal with them. Participants realize the need for on-going services. 2. Length of time to treatment is shorter. 3. 4 doctors were educated about the underserved population of those needing mental health services
Depression Awareness and Stigma	1. Held Perinatal and Postpartum Depression Forum in May 2002. Activities included a demonstration of the use of the Edinburgh Postnatal Depression Scale and a presentation by a person who experienced postpartum depression. 2. Published resource manual and pamphlet on depression Restarted the Healthy Start newsletter in Sept. '04.	Pfizer Pharmaceutical, Inc. Allegheny County Health Department, Western Pa. Home Health Care, University of Pittsburgh Center for Minority Health, Magee Women's' Hospital, Family Foundations, Dr. Katherine Wisner, Dr. Edyee Moses	1. 85 attendees representing 22 mental health and human services 2. Educated attendees on signs & symptoms of postpartum depression, and the effects of depression on family members.

Consortium

By 5/31/2005, maintain at least 50% (9) consumer representation on the Healthy Start Board of Directors.	Created Board Operation Manual Board of Directors Bylaws Training on consumer advocacy Provided training on leadership skills Promoted ownership Provided mentorship and guidance Enabling Services Provided transportation (vans, bus tickets) # Provided nutritional supplements at meetings provided childcare to (4) consumers (services, reimbursement)	Perinatal Systems Liaison, Executive Director, Board of Directors University of Pittsburgh Medical Centers (UPMC) Western Psychiatric Institute and Clinic University of Pittsburgh, Graduate School of Public Health UPMC Magee Women's Hospital	33% (6) consumer representation 100% received training on leadership, cultural sensitivity and competence
By 5/31/2005, increase to 33% consumer representation on the regional Consortia	Outreach and Recruitment Canvassed targeted communities Sponsored 35 educational activities in the community Heightened awareness about infant mortality Provided individualized attention and positive reinforcement Provided specific trainings to address individual community need Enabling Services Provided transportation (vans, bus tickets) # Provided nutritional supplements at meetings provided childcare to (20) consumers (services, reimbursement)	Perinatal Systems Liaison, Healthy Start Multidisciplinary Team, Six Regional Consortia	35% (38 of 109) consumer representation Increased consumer participation by 30%.
By 5/31/2005, increase the capacity (knowledge and skills) of new consortia members to 100% through provided training of Perinatal disparities and risk reduction	Brochures, pamphlets, and Fact Sheets Developed an educational/orientation manual for new members Distributed education fact sheets at (144) meetings (40) new members Provided (96) trainings to all members	Perinatal Systems Liaison, Six Regional Consortia, Hilltop Community Health Center (federally qualified health center), National City Bank, Goodwill Industries, Women's Center and Shelter, University of Pittsburgh Center for Minority Health, YWCA of Greater Pittsburgh Mercy Health Plan, Gateway Health Plan	100% (109) received training on Perinatal disparities and risk reduction

B. Service Model Manual

See attached folder titled "Mentoring Materials"

V. Project Impact

A. <u>Systems of Care</u>

1.
The Healthy Start program uses an array of approaches to enhance collaboration. The community consortia represent multiple organizations, including health, human services, business, government, faith-based, as well as consumers. The Healthy Start staff is involved in many community organizations and task forces that represent programs serving the Healthy Start communities; these include task forces related to health disparities, fatherhood, child development, health professional education, and mental health, among others.

The Healthy Start health education and outreach program is another important strategy to enhance collaboration; Healthy Start offers training that is relevant to the maternal and child health and cultural competency training that is offered to community partners also serving Healthy Start families. The Healthy Start program also participates regularly as members of community panels, conferences, community forums, health fairs and testimony for public health issues; these also are approaches encouraging collaboration.

The Healthy Start program also is supportive of collaborative proposal writing and grants writing with partners serving families and collaborates with technical assistance, as a partner for referrals or collaborative service delivery.

Collaborative student training is another vehicle for collaboration; the Healthy Start program is an active preceptor organization for many health professional students and works closely with the South Western Pennsylvania Area Health Education Center, which facilitates practical experiences for nursing, public health and other health professionals. These relationships with health professional schools and the SW PA AHEC also reinforce collaborative training opportunities for Healthy Start as trainers and promote multidisciplinary services.

The Healthy Start program also is active in public relations with the community through its distribution of newsletter to community residents, providers, and those interested in Healthy Start; Healthy Start program Board of Directors, and staff also frequently serve as panelists for news programs, radio, and other programs that are joint efforts promoting quality of life in Healthy Start communities.

2.
The Healthy Start program had an intensive case management system that had been operational for more than five years at the beginning of this project period. Services with local health, human services, education, community leadership groups, and local government officials were well-

established. During this project period, the service integration changes have been enhancements to the case management system as well as more in-depth services to specific populations.

Healthy Start has increased the scope and depth of its services to boys and men during this project period. The Male Initiative Program offers a community-based approach to men who are parents of children who are participants of Healthy Start. The program mission is to offer preventive services in a holistic fashion to men who are usually experiencing educational, employment and interpersonal problems as well as learning skills as a parent to a young child. In many cases, the men also lack health insurance, may have a history of substance use, substandard or unstable housing arrangements. The preventive services for depression, health screening, and employment and education referrals are important to men caring for themselves and thus being able to provide for their children. Healthy Start also has a strong commitment to the quality of life within the communities in which it serves and addressing the high social and health problems of young men in these communities is critical to improving the overall quality of family and community life.

Preventive mental health services continue to be an emerging strength of service integration for Healthy Start. Although initial concern was based on symptomatic cases of severe depression, and other serious mental health issues of participants and their partners, the Healthy Start program has evolved during this project period to include screening for depression among all participants, women and males and to provide counseling and referrals for therapy, medication or other community-based programs such as faith-based counseling, support groups. Healthy Start has developed and expanded their community partnerships with traditional services for mental health such as the Western Psychiatric Institute and Clinic, a national leader in the treatment of depression; these partnerships have included a focus on postpartum depression identification and treatment as well as cross-training of Healthy Start and WPIC providers and other community partners about the signs, symptoms and treatment of postpartum depression and its symptoms and cultural issues involved with postpartum depression among African American women. Cultural competency in the screening and treatment of depression has been a central theme of the collaboration of WPIC and Healthy Start as they work together to develop and implement effective models of care for families using Healthy Start services.

Interconceptional care also has expanded during this project period as the Healthy Start program continues to develop and increase its relationships with the local pediatric and child development community. Healthy Start uses an interdisciplinary approach for children and the nurse screening protocols emphasize child developmental milestones, infant mental health and parenting, and the preventive health of children including a medical home and immunizations. The integration of depression screening and treatment, violence prevention education and referrals, as well as a protocol for prenatal parent education promotes the well-being of both the parents and the children in the interconceptional period. Health promotion for the mother includes assurance of postpartum care, a primary care provider, referrals for health needs such as chronic disease management, educational counseling and referrals and employment counseling and referrals.

The Healthy Start case management system also uses a multi-disciplinary approach using a team of nurse, outreach worker, male initiative specialist, and social worker; these core members

provide services, referrals and health education and promotion. The teams serve regions that are geographically-based. Assisting the teams are clinical coordinator, male program specialist, field manager as well as information and referral specialists, program assistants, data abstractors and administrative assistants that offer support to the service providers. The Healthy Start program also fosters a continuity of care within neighborhoods with collaborations with the local federally qualified community health centers and the family support centers each of which address the medical and social support needs of the families.

3.

A.
The Healthy Start program has been instrumental in the enhancement of many collaborative partnerships within the Pittsburgh/Allegheny County region. The partnerships related to maternal health involve those with all the local hospitals serving obstetric and gynecological needs, these include tertiary sites as well as community facilities, the federally qualified community health centers offering primary care to women, the Allegheny County Health Department programs for maternal and child health, nutrition, WIC, chronic disease, infectious diseases, (including sexually transmitted infections, and immunizations) family planning programs such as the Family Health Council, the Tile X grantee. The Healthy Start program also collaborates with the Mid-Atlantic HIV/AIDS Education and Training Center.

While many of these relationships have been ongoing and stable for the project period, several initiatives have grown during this project period. These include those related to tobacco use, cultural appropriate approaches to health promotion and disease prevention, and depression screening and treatment.

The prevention and control of tobacco especially related to smoking during pregnancy, second-hand smoke exposure by children of smokers, and efforts for clean air in the Healthy Start communities. have been key activities during this project period. Healthy Start has been active in several local task forces and efforts to reduce prenatal smoking as well as Clean Air for Healthy Children. These involve both local and state partners with the PA Department of Health and other health associations such as the American Cancer Society.

Another effort has been the strengthening of Healthy Start activities with the cultural approaches to the prevention and treatment of chronic diseases and health habits that seek to use culturally appropriate approaches to health education, communication and community-based approaches. These partnerships include Healthy Heart and Souls, and the University of Pittsburgh Center for Minority Health that addresses health disparities (e.g. cardiac, diabetes, cancer, infectious diseases, mental health, and infant mortality) within the Pittsburgh area.

Healthy Start also has been a leader in the community in addressing the screening and treatment for depression between pregnant and parenting African American and other economically disadvantaged women. The program has had an active partnership with Western Psychiatric Institute and Clinic nationally known depression treatment program. The partnership has led to culturally appropriate methods of screening and treatment approaches for African American young women living in poverty neighborhoods and also comprehensive staff training for Healthy

Start staff so that universal screening is completed for the signs and symptoms of depression among Healthy Start families and the available resources for referrals for treatment, including therapy and medication are known and used appropriately.

The Healthy Start program also has acted as a leader in facilitating other key relationships in the child health and child development community especially related to the concerns of African American families and children. Healthy Start is in a unique position of a long-term relationship with families during the prenatal period through the infant and toddler stage, the program has the capacity to impact preventive health and mental health for children through preventive interventions with the parents during the prenatal period as well as early childhood. The Healthy Start program has continued to strengthen its ties with the local pediatric facilities including Children's Hospital of Pittsburgh, all tertiary sites for neonatal intensive care, early intervention services for Allegheny County, the Alliance for Infants, PA SIDS Alliance, Pressley Ridge, Auberle Center, Family Resources, Fatherhood Collaborative, PA Dept of Public Welfare, PA Department of Children, Youth and Families. The increased emphasis on fatherhood and the screening and detection of depression and violence prevention efforts also has been important strategies that have grown during this project period.

Healthy Start also has continued to increase its relationships with all levels of the education community in the Pittsburgh /Allegheny County community. The Healthy Start staff has expanded their preventive programming within the Pittsburgh Board of Education to offer programming especially focused on healthy role models for young African American boys and young men though the Male Initiative Program specialists. The Healthy Start Male Initiative program that provides services to the male students and their families offers workshops, joint events, and technical assistance. Healthy Start also continues its presence with pregnant and parenting students in the local schools through ongoing relationships with school educators, health professionals, and parents; referrals and case management as well as follow-up services for the postpartum and interconceptional period and case management of the infants and toddlers are provided to students within the local schools. The Healthy Start program also collaborates with the Allegheny County Community College through education and staff training, and referrals of participants to educational and vocational programs at local sites.

The Healthy Start program also has continued to expand its role as mentor and preceptor for many health professional students though its relationship with the Southwestern PA Area Health Education Center also based in the same office complex. The SW PA AHEC serves to facilitate the placement of health professional students with Healthy Start through short-term practical, workshops, and experiential and service learning opportunities so that students become more aware of the knowledge, skills, and attitudes required to serve the Healthy Start families. The Healthy Start staff also regularly serves as guest speakers for many classes at local schools and universities, including the University of Pittsburgh Graduate School of Public Health, Child Development, Social Work, Nursing, and others.

B.

Healthy Start's central focus has been the inclusion of consumers as decision-makers in the program planning, implementation, and assessment. The Healthy Start Board of Directors includes many community leaders and residents who are active in offering their voice to the

community health decisions. The Consortia members include representatives of the Young Men and Women's African American Heritage Association, Hill House Association, Council of Three Rivers Indian Center, local faith-based leaders serving the Healthy Start neighborhoods among others.

Healthy Start also has had strong relationships with the community centers based in many of the Healthy Start neighborhoods; these programs offer recreation, health, tutoring, after school and other child care, employment and training referrals, as well as host many community events and groups such as health fairs, children's classes, clubs and support groups. Healthy Start has long-term ties with several local programs such as these including Hill House, Hosanna House, Kingsley Association, Boys and Girls Clubs, YMCA, YWCA, Urban League, Gwen's Girls (preventive services for young African American girls), local ministerial associations, and the family support centers based in Healthy Start neighborhoods. These ties reinforce the community and consumer participation that is central to the Healthy Start program mission. These ties also serve as important links to outreach for new families for Healthy Start programs as well as offer recreation, education, childcare, and faith-based services for Healthy Start families to assure quality of life.

4.

A.
Healthy Start serves as an advocate for all participants to assure that they receive the services that they need for optimum health for their children and themselves. The Healthy Start staff regularly receives in-service education and training regarding changes to intake and referral and eligibility requirements for all services e.g. child care, economic assistance, substance and mental health services, health insurance, among others. Healthy Start also regularly invites key health and human services professionals to provide training and technical assistance to Healthy Start as the participant needs arise or new procedures are implemented. Likewise, Healthy Start also works in collaboration with local and state partners to address eligibility issues for populations such as those served by Healthy Start. These may involve meetings with the PA Department of Health, Public Welfare, or county programs serving health or human services for the participating families. The case management system of Healthy Start involves screening, referral and home visits, case review, assistance provided with completing forms, assistance for participants to complete data required for eligibility for Medicaid, Title X, assistance with the application process, accompany participants to visits with health care providers, advocate for primary care within underserved communities.

B.
The primary focus for this project period has been increasing access to services for mental health needs, especially depression, addressing culturally appropriate approaches to health and human services, increasing access to tobacco cessation and smoke free home and neighborhood environments, increased family services for fathers, and more community ties with dispersed neighborhoods as the families served by Healthy Start were relocated to an array of housing within the county when the "public housing community" approach was abandoned as a housing policy.

Healthy Start addressed the mental health needs during this project period by increasing collaborations with mental health providers including those offering depression screening and treatment, mental health services, support groups, and family resources centers. Healthy Start also began universal screening for depression among its participants and their partners and provided assistance with competing applications or other assistance for obtaining counseling, or medication. Healthy Start also increased its staffing to employ a masters level LSW to direct a program of depression and mental health services and to offer in-home visits for assessment and screening of depression. The social worker also serves as the liaison with local agencies providing mental health services and acts as the coordinator for advocacy and seeking opportunities for program funds for enhanced mental health services.

Healthy Start also has continued its mission of culturally appropriate care for Healthy Start families. The Healthy Start staff devote substantial hours to education of the participants about the services as well as addressing their concerns about seeking services, possible barriers such as transportation and child care, and provide assistance as needed to accompany them to services and to assist with communication as needed. Healthy Start collaborates with local health and human services to develop culturally appropriate services and approaches and during this project period, several efforts focused on tobacco use, smoking cessation, clean air, and cardiac and hypertension prevention, screening and treatment. Healthy Start staff collaborates with local organizations such as Healthy Heart and Souls, Center for Minority Health, Urban League and others to eliminate barriers related to culture.

The health of African American males has been another key effort that has expanded during his project period. The Healthy Start program has been active with the Fatherhood Collaborative and provides services and educational programs that are standardized curriculum developed by experts in fatherhood and the social and psychological aspects of fatherhood among African American men. The Healthy Start program has increased its ties with local employment, education, mental health and juvenile justice programs serving young men as well as promoting more health services for young men who often have no health insurance through assisting them with eligibility requirements and referrals to community health centers.

The barriers to services for Healthy Start families continues to involve access to transportation, child care, tangible goods, emergency assistance for food, housing, and clothing. Healthy Start families also experience crises such as those related to family violence, homelessness, medical crises, among others for which they often have few financial or family resources to address these crises. Healthy Start offers emergency assistance and referrals as needed, transportation, bus tickets, van services, childcare referrals and vouchers, assistance with obtaining childcare subsidies, obtaining emergency food and clothing. These needs are ongoing with Healthy Start families and the capacity to provide assistance is very limited by Healthy Start resources and policies so collaboration with local organizations is central to assuring emergency assistance is provided, and follow-up case management to determine remedies for the problems are dealt with by the Healthy Start staff for housing, food, or other long-term issues.

C.

Care coordination is addressed within the case management system of Healthy Start. The interdisciplinary teams have regular case conferences with supervisors and care coordinators, all

activities with participants are documents and case records involve the completion of detailed forms and protocols that are reviewed and monitored regularly by supervisors. The Healthy Start process also involves review of referrals and completions of referrals as documented by the case records, communication with participants, and others documentation as provided by the referrals source. The case management system involves home visits, prenatal and postpartum risk assessments every six months, ongoing referral and monitoring, weekly case reviews and case conferences, establishment and tracking of medical homes, ongoing transportation and child care arrangements, documentation, documentation and tracking of immunization, health education and parenting education. The extensive network of community organizations and health, education, human services and neighborhood programs also are included in the care coordination activities as the case management system documents these referrals and service utilization by Healthy Start families.

D.
During this period, Healthy Start has expanded its staff for data management and has hired staff with data management and data systems skills for both systems development and analysis for program administration and planning. All participant forms are maintained in the Healthy Start Management Information System. All participant information is placed in the case management reminder system. The system offers prompts to the case managers for a series of required activities that are time-sensitive; these include home visits, reminder cards for appointments, telephone calls. All visits dates, risk assessment data and other health and risk assessment forms are entered into the MIS. Documentation includes WIC enrollment, linkages and referrals to other local programs, early intervention, parenting education, and primary care. The Healthy Start MIS also maintains protocols to assure that referrals are verified and services rendered. Impact on enhancing client participation and evaluation of service provision

5.

A.
Healthy Start family input is sought on an ongoing basis; all participants are encouraged to report concerns and needs to the Healthy Start program office; participants are able to attend meetings of the consortia in their neighborhoods and provide input to Healthy Start. Consumers serve as Board members for Healthy Start. Staff is hired from the local neighborhoods and former participants are current staff.

Healthy Start has an extensive network of partner organizations within Pittsburgh/Allegheny County and conducts in-service programs, community events, staff trainings, and consumer satisfaction with Healthy Start families and those residents living in Healthy Start neighborhoods. Healthy Start is a facilitator of events and services that address cultural competence and regularly conducts cultural competency programs for its staff and other providers who serve Healthy Start families.

Sensitivity to cultural, linguistic and gender needs for this project period have focused on increased services for the African American male in Healthy Start communities. The Male Initiative Program targets fathers who are likely to need extensive support in the fatherhood role. The program uses the Healthy Start approach of home visiting and case management with male

program specialists, program resources e.g., prisoner reintegration, male behavioral health, and child support/legal support. The monthly family focus nights offer education on social and health topics and offer an informal mentoring and support network for new fathers.

B.
Consumers are members of the Consortia and contribute to the development of assessment and intervention. Healthy Start also receives comments through community forums, focus groups, and meetings with neighborhood consumers. The Healthy Start families are active in the design and methods involved in local evaluation. The local evaluation studies conducted during this project involved a survey of consumer satisfaction with Healthy Start services and referrals and a study of the needs for baby items and other tangible goods. Healthy Start participants reviewed the study topics, questionnaires, methods for data collection, and reports and provided suggestions for all aspects of the studies. Consumers also provide input regarding all Healthy Start interventions including the Helpline, health education, and case management and referrals on an ongoing basis; approaches include phone calls, post-cards, questionnaires, focus groups, or community meetings.

B. Impact on the Community

1.
Healthy Start has a long-standing interest in community awareness of services and resources. The services are neighborhood-based and provide a presence of a core team within the local neighborhoods. Healthy Start outreach workers wear Healthy Start uniforms (monogrammed baseball caps, umbrellas, attaché cases, blue shirts and khaki pants) so as to easily identify. Healthy Start participates in numerous community events in the Healthy Start neighborhoods such as job fairs, health fairs, and community days as part of the overall public relations of the program. Outreach and recruitment efforts involve canvassing the communities and sponsoring educational and informational services, specific training to address individual and community needs, distribution of brochures and fact sheets to communities, hiring of local residents as Healthy Start staff, provide van service and travel throughout the project area and county to provide information regarding need for early and regular prenatal care. Healthy Start also participates in several local collaborations with health and human services providers, family support centers, family childhood initiative, Early Head Start to foster sharing of knowledge and health education for participants. The Healthy Start program also collaborates with providers for specialty services such as those involving substance use, family violence and incarceration, justice and legal system, employment and vocational resources.

2.
The Consortia is the primary method by which consumers are involved with setting or changing standards. Healthy Start families also are encouraged to participate in consumer groups related to their own needs and interest such as eliminating racism and health disparities, a specific disease such as heart, cancer, or a family concern such as family violence, imprisonment of family members. Through these vehicles, the Healthy Start families are able to participate actively in policy changes.

3.
The Community Consortia are the primary teams for working with divergent opinions and resolving conflicts within the communities. These serve each of the Healthy Start regions and represent community residents from an array of backgrounds that have many differing views on neighborhood issues affecting families. The Healthy Start program also involves team building with the Fatherhood programs as the fathers deal with often-conflicting problems of employment, housing and partner social relationships. The community collaborations of Healthy Start also involve facilitating partnerships among many groups including business, faith community, justice and legal system, housing in addition to those representing health and human services. Each Healthy Start region and its consortia has been active in working on local problems and issues affecting pregnant women, young children, and parents that directly or indirectly affect the quality of life in their communities e.g., safe and affordable housing, increased crime, declining access to public transportation, closure of neighborhood schools, limited access to grocery stores, change in location or availability of health providers and insurance coverage, clean air and healthy environment.

4.
The Healthy Start program hires local residents for its program. It also offers ongoing and intensive in-service training and encourages Healthy Start staff to continue their education to advance their knowledge and skills. Healthy Start also offers case management for all Healthy Start families for completion of their education, employment referrals, training referrals, and support for those re-entering the work force.

C. Impact on the State

Pittsburgh/Allegheny County Healthy Start has had a central role in the state leadership of collaboration between Title V and Healthy Start programs within Pennsylvania. The former Executive Director was a founding member of the Pennsylvania Perinatal Partnership and served as Chair for several years. The current Executive Director likewise is an active leader in the organization, serving as Chair of several task forces and roundtables, most recently perinatal depression, roundtable on services for children with special health care needs, among others. The Pennsylvania Perinatal Partnership has brought together Title V and Healthy Start programs in Pennsylvania with other policymakers including the Departments of Public Welfare, Insurance, Education, and Health. as well as state officials and insurance and health providers.

The Executive Director of Pittsburgh /Allegheny County Healthy Start has been an active leader in the Pennsylvania Perinatal Partnership during this project period. The group meets six times a year and during this project period, some of the highlights of their activities were serving as advocates and providing community education about the malpractice crisis in Pennsylvania and the impact on access to obstetrics, especially in rural Pennsylvania, review of services and program of the state children's health insurance program SCHIP, review and impact of managed care plans on services for prenatal, postpartum and interconceptional participants as well as pediatric coverage, transportation services for medical and human services , and the impact of migration of undocumented families into Pennsylvania and their health and human services needs. Pittsburgh/Allegheny County Healthy Start in collaboration with the Pennsylvania Perinatal Partnership (PPP) also participated in developing and implementing a statewide

training program for all Pennsylvania Title V and Healthy Start staff to learn about the new privacy laws and regulations for HIPAA.

Participation in the PPP also has an impact on programs and the quality of health services in rural Pennsylvania. Since Pennsylvania has few local health departments and these are only located in large cities, the rural areas often have few services and coverage only from a regional office of the Pennsylvania Department of Health that serves multiple jurisdictions. The Pennsylvania Perinatal Partnership was instrumental in assisting those programs such as the rural Healthy Start program based in Fayette County Pennsylvania to have ready access to education, advocacy, and mentoring by maternal and child health leaders and to meet and present their issues to state leaders in agencies that impact their services.

The Pittsburgh/Allegheny County Healthy Start program also has had an impact on the Pennsylvania workforce since it serves as a practicum site for nursing schools throughout Pennsylvania. Nursing students complete practical in the Healthy Start communities and return to their home communities, often in rural Pennsylvania, with increased knowledge and skills about cultural competency and diversity as well as the Healthy Start case management model with an interdisciplinary team and consumer/community collaborative model of planning, implementation and assessment.

D. Local Government Role

Since its initial funding the Pittsburgh/Allegheny County Healthy Start has been active in working with the local government. The Allegheny County Health Department served as the grantee for this project period until the transition to a more independent operation. The county health department remains supportive of the Healthy Start program and is a key partner in programs and services in the community. Likewise, the elected officials representing Healthy Start neighborhoods also often seek information about the needs of Healthy Start families. Healthy Start staff has provided professional presentations at the request of various government officials to many local, city, county and state government officials and their staff about Healthy Start families and program recommendations for policies affecting the residents.

E. Lessons Learned

The Pittsburgh Allegheny County Healthy Start program continues to improve its services and to address the changing needs of its participants. The program's mission remains community focused and seeks community and consumer input, addressing as many needs of its' families either through direct services or through collaboration and advocacy for new or expanded services.

VI. Local Evaluation

HEALTHY START LOCAL EVALUATION REPORT

PROJECT NAME: Pittsburgh /Allegheny County Healthy Start Program
TITLE OF REPORT: Consumer Survey Report
AUTHORS: Christine Ley

Section I: Introduction
Local Evaluation Component

A.
The impetus for the local evaluation was the Board of Directors and staff that requested a survey of participants to determine their satisfaction with the Healthy Start program, its staff, and the referrals. The local evaluation was designed in a collaborative method with a team of the local evaluator, Healthy Start consortia, Board and staff all providing advice and expertise in the methods, design and implementation of the survey. The local Healthy Start evaluator Christine Ley, University of Pittsburgh, was the lead for the team providing technical expertise and guidance. The history of the evaluation was based on the request of the Board to determine participant satisfaction and to assess satisfaction with programming. Since the budget for public relations, community education, and tangible services had been markedly reduced or in some cases, eliminated, there was perceived a need to examine the impact on participant satisfaction. The components of the evaluation included a mailed written questionnaire that was distributed to all active participants as well as those who had received services within the past year, a total of about 1000 participants.

B.
The type of study was a formative evaluation designed to assist the program in improving its services and meeting participant needs within the context of its available resources. . The community and consortia also did not want a sampling of the participants so all participants were mailed a questionnaire at the last known address. The packet included a SASE, questionnaire and a letter requesting their completion of the questionnaire.

Key Questions /Hypotheses
The key questions for the evaluation included the participants' satisfaction with the Healthy Start services, staff, and referrals as well as the perceived benefits of the program and suggestions for program improvement.

Section II. PROCESS

A.
The procedures for conducting the local evaluation were collaborative and involved the Healthy Start Board, community consortia, staff and participants. The community and consortia were integral to the evaluation as they were active in the design, selection of the data elements, reviewed the questionnaire and provided feedback for changes in items, wording, language; the community and consortia also requested complete confidentiality so no tracking numbers were permitted for follow-up. The entire team reviewed the options for contacting participants, determination of inclusion criteria, confidentiality, content, format, and language of the questionnaire. Readability, cultural sensitivity, burden on respondent, and confidentiality were the key guiding principles guiding the team. The local evaluator implemented the design and methods for the survey as requested by the consensus of the Healthy Start input from all parties. The method for data collection was a survey consisting of a written questionnaire that was completed by each participant and returned with a SASE. No identifying information was

included for tracking or follow-up purposes for the survey at the request of the community. The sample included all active participants as well as those enrolled within the past year. No comparison or control groups were used.

A.
The data source was the written questionnaire.

B.
The instrument consisted of items related to receipt and satisfaction with Healthy Start core services, receipt and satisfaction with referrals to community agencies and services with the assistance of Healthy start staff, perceived benefits of Healthy Start services (list of six benefits and other option), participant statements of reasons for Healthy Start not meeting their needs (open-ended qualitative) participant referrals to Healthy Start (yes/no), participant reasons for referral or not referring to Healthy Start (open-ended qualitative) and suggestions for program improvements (open-ended qualitative). Demographic data included ethnic group, age (less than 18 years of age/18 or older), Neighborhood and zip code (program region matching for administrative purposes).

Section III. FINDINGS/DISCUSSION

The limitations of the evaluation were due to the inability to follow-up or track participants for a higher response rate. The Healthy Start program was interested in complete anonymity so while the evaluator described the expected low response rate if follow-up was not completed by tracking, the Healthy Start program did not want follow-up. The response rate was 20 percent for a total of 202.

The majority was 18 years and older (74%), Seventy-four percent were African American, 18 percent White. The demographic characteristics were representative of the overall Healthy Start program consumers. All Healthy Start regions were represented.

The services most frequently used were home visits by outreach workers (94%), home visiting by nurses (85%) and Helpline (50%). Teens 17 and younger used the services with about the same frequency as women 18 and older. Regions showed similar patterns of use. The services were highly ranked. Ninety percent rated their home visits by the outreach workers as "Excellent" or "Good". Eighty seven percent rated their home visits by nurses as "Excellent" or "Good". Eighty-four percent rated the Helpline services as "Excellent" or "Good". There were no differences in perceptions of services by young teens as compared to women 18 and older. The trends were the same for all regions.

The most frequently used referrals were for WIC and other food services (68%) and emergency assistance (64%). Referral services were highly ranked: WIC 99% "Excellent" or "Good", Family planning 94%"Excellent" or "Good", Parenting Education/Support, 91% "Excellent" or "Good" and Emergency Assistance 88% "Excellent" or "Good".
The participants most frequently reported that Healthy Start services were beneficial because it "helped with my baby", 66%,"helped learn about services"64%, and "reduced my stress", 51%.

Almost all (95%) reported that they would refer someone to Healthy Start and the majority (54%) reported that they had referred someone to the Healthy Start program. The primary reason that respondents reported for referring a family to Healthy Start was because of the support and help (87%).

Suggestions for program improvements included providing more community information and advertising about the program and more outreach in schools so that pregnant students and young mothers would learn about the program. Other suggestions included more funds for tangible aid, emergency assistance and more baby items such as diapers, formula, and cribs, transportation services with expanded service hours for a van, more social family events and more community events for Healthy Start families.

The findings indicated that Healthy Start consumers were satisfied with the services that they have received, and were willing to refer other families to the program. The Healthy Start program has provided for more than a decade in the Pittsburgh/Allegheny County area. However, more resources were available in the prior years of operation for public relations and advertising such as television, radio, billboards and community education events than are available with the current program resources. Therefore, there may be less public awareness of the program. Historically, Healthy Start began in this community more than ten years ago with a generous budget and was able to have comprehensive public relations, including media spots such as television, radio, and billboards, and other public relations community programming. There were more resources for community family events as well as the ability to provide more tangible goods and emergency aid. As the program has evolved, it has had to reduce some services that while considered non-essential to the program, may have been very significant to the consumers such as tangible goods, emergency assistance and social events in the community.

First, the resources of the Healthy Start of today are not the resources of the Healthy Start program that began in this community more than a decade ago. This discrepancy can cause individual and community "disenchantment" with the Healthy Start program, as it no longer is the "same" program as they experienced in the past. Some mothers specifically commented that they had received "more" for previous pregnancies, usually in the form of tangible goods or more home visits. While the core mission and services remain the same, the ability to provide comprehensive services to all at-risk women in the community is limited by budget, staff, and the intensive case management needs of many families.

Second, while the majority was overwhelmingly satisfied with the core service of Healthy Start, the home visiting and support services of the outreach and nursing staff, others were concerned about the number and frequency of home visits. A clarification in a brochure or other written documents as suggested by one consumer is a positive suggestion. Knowing the "expected" number and frequency of contact with Healthy Start staff may be helpful to clarify the program as some consumers felt they didn't receive enough contact while a few felt the staff were "in their business".

Third, consumers also suggested that more public relations be used to promote Healthy Start more extensively in the media so that more women in the community are aware of the services. While the program is more than a decade in operation younger women in the community would

not benefit from advertising and other community efforts such as billboards and radio, television from several years ago and may be unaware of the program.

Finally, the findings illustrate the importance of the Healthy Start program reviewing the scope and depth of its services and its ability to provide intensive case management services for all eligible women and their families. Staff turnover, more service mandates e.g. depression and substance use as well as geographic dispersal due to the closure of many public housing units, and the requirements of welfare reform with more women attending school or work are factors to consider. While the consumers suggested more advertising and community outreach to bring more women and families into the program, the program may want to consider the number of families and the scope of services that it can provide effectively.

Section IV. RECOMMENDATIONS

A**.**
The primary recommendations included review of the communications for potential Healthy Start families to clarify the scope of services and the limits of program resources. The program previously had more resources for community events, tangible goods, and community programming that is not available as the budget decreased over time. The findings also suggested that the program determine the number of participants and service that would be feasible to impact health outcomes, given the large number of eligible families within the target regions and the increasingly limited resources with more mandates for services.

B.
The findings regarding the concern of participants for tangible aid led to the development and implementation of a follow-up study of the tangible needs of Healthy Start families.

Section V. IMPACT BASED UPON THE RECOMMENDATIONS/RESULTS OF THE LOCAL EVALUATION

A.
There has been ongoing interest in the Allegheny County region including multiple agencies such as the Allegheny County Health Department and others regarding the dearth of tangible goods for new mothers and young families. The Allegheny County Department of Health maternal and child health program and local pediatric, and child health leadership have convened community meetings about these needs.

B.
The Healthy Start program requested an additional study of the Healthy Start participants to determine the extent and type of needs for tangible goods and related referrals.

Section VI. PUBLICATIONS

N/A

HEALTHY START LOCAL EVALUATION REPORT

PROJECT NAME: Pittsburgh /Allegheny County Healthy Start Program
TITLE OF REPORT: Baby Item Needs Assessment Report
AUTHORS: Christine Ley

Section I. INTRODUCTION:
Local Evaluation Component

A.
The purpose of the survey was to determine the availability and use of baby items and products as well as barriers to their use. The Healthy Start program participants, staff, and residents of the community historically have expressed concerns for the perceived problems of young families within the Healthy Start neighborhoods having access to adequate and safe baby equipment and products. Availability of cribs and the education of parents about safe sleeping arrangements are key issues for many families and their children. The findings of the Healthy Start consumer survey also showed that participants continued to express concerns that Healthy Start was not able to provide for these needs.

B.
The type of study was a formative evaluation designed to assist the program in improving its services and meeting participant needs within the context of the available resources. The participants completed a written questionnaire.

Key Questions/Hypotheses

The key questions included the participant needs for emergency assistance for food, clothing, baby equipment, and their support for receiving these services. The questionnaire also addressed items about the infant sleeping arrangements and parental preferences.

Section II. PROCESS

A.
The procedures for conducting the local evaluation were collaborative and involved the Healthy Start Board, community consortia, staff and participants. The purpose of this survey was to provide data on general trends and problems of Healthy Start mothers about their needs for baby equipment with a brief questionnaire. A two-week data collection period was selected for distribution of the questionnaire to all postpartum and interconceptional participants receiving a home visit by Healthy Start staff. The questionnaire was constructed with the mutual participation of Healthy Start program staff and administration in collaboration with the University of Pittsburgh evaluator. Content, length, readability, cultural sensitivity and data collection methods were mutually decided by this collaborative team. No comparison or control groups were used.

B.

The data source was a written questionnaire. The content of the questionnaire focused on key areas of interest to Healthy Start, Inc. that were important to determine availability of baby items, barriers for obtaining and using items, sleeping arrangements for infants, reasons for sleeping arrangements and emergency needs for baby products. Suggestions and comments about these items, the need and receipt of emergency assistance for baby items, including food, formula, diapers, and various baby equipment items, support services, problems in receiving these services, frequency of receipt of emergency services were included. Infant sleeping arrangements, use of a crib or bassinet and parental preferences for sleeping arrangements were also included in the questionnaire. Suggestions for program improvements were requested. Demographic data included age and neighborhood. Neighborhood and zip code were requested to determine possible differences in program regions.

Section III. FINDINGS/DISCUSSION

A total of 152 participants completed the questionnaire during the data collection period. This number represented about 30 percent of the total Healthy Start participants with infants. (Note: Only those participants receiving home visits during the data collection period were asked to complete the questionnaire.) Eighty-six percent were 18 years of age and older. All seven regions of the Healthy Start program were represented in the total of 152 respondents.

Cribs were the most frequent need with more than one in four reporting that they did not have a crib. About one in five reported not having a baby carrier. There were regional trends in need for baby equipment with three Healthy Start regions (Regions 2, 3 and 6) reporting that more than 40 percent did not have cribs. Overall need for equipment also varied by region when comparing the cumulative need for all six items (crib, mattress, bassinet, car seat, and carrier). Two Healthy Start regions (Regions 3 and 6) reported more overall need as compared to other regions.

About half of the respondents (53%) reported that a crib, bassinet or cradle was the usual sleeping arrangement for their child. More than one-third (37%) reported that the usual sleeping arrangement was sleeping in the parents' bed. Respondents seldom reported that the infants slept in a sibling's bed.

The possession of a crib by a family did not assure that the crib was the usual sleeping arrangement for the infant. When examining the number reporting having a crib with the number reporting crib as usual sleeping arrangement, sleeping patterns may be determined. In some regions, respondents reported that more than 30 percent or more of infants with cribs did not sleep in the crib.

Respondents reporting that they did not have a crib were asked to select reasons for not having one. More than 90 percent reported that it was too expensive or they could not afford. Less than ten percent reported that a crib was not necessary. More than one-third also reported that the infant slept in the parents' bed.

The majority of respondents reported that they needed financial help from others on a monthly or more frequent basis to obtain diapers, formula or baby clothes. All regions reported that the majority of mothers needed help obtaining diapers on a monthly or more frequent basis. Two regions (Region 5 and 6) reported that more than 75 percent required assistance. Although many participants are enrolled in WIC, the majority also reported needing monthly financial help in obtaining formula. The need for help with obtaining baby clothes also was high for most Healthy Start regions.

Respondent suggestions focused on Healthy Start offering these items to Healthy Start participants particularly on a crisis basis as well as advocating for more local services and organizations to also provide these items for children. They also requested help obtaining items including baby gates, safety plugs and other home safety items.

The findings indicated that there appears to be a substantial need for addressing the availability of baby equipment for Healthy Start participants as well as education about safe sleeping arrangements. Only half of the mothers reported that the "usual sleeping arrangement" for their infant was a crib. One of two mothers also report needing financial help at least monthly from someone else to help obtaining baby products, especially diapers and formula. One of four mothers reported that they did not have a crib. More than one of three reported that their infant slept in the parents' bed. Having a crib likewise did not assure the infant using a crib as the "usual sleeping arrangement".

Clearly Healthy Start participants experience substantial difficulties obtaining the minimum necessities for their infants. Not having enough diapers or formula is a frequent problem, according to the respondents. Many lack basic equipment to care for the infant. Almost no mothers reported having the usual supply of equipment for their infant that are "standard" for most families in the United States, e.g. crib, car seat, stroller, baby carrier. Owning a single item such as a stroller was most common. Stroller ownership most likely was most common due in part to the low cost of many strollers such as umbrella models.

The remedies for addressing these issues are difficult since there are few resources for supplying items such as cribs for parents in economic need. These issues often precipitate a dilemma for the Healthy Start program. Healthy Start staff provides education for healthy behaviors, yet many Healthy Start participants lack the income or family resources to follow through with the advice and education. For example, although Healthy Start seeks to promote safe sleeping arrangements for infants by health education for parents, the program does not supply cribs and community resources are limited.

Promoting safe sleeping arrangements for Healthy Start families involves several activities, including: obtaining the baby equipment, educating parents about safe sleeping arrangements, and follow-up to reinforce safe sleeping arrangements. Obtaining the equipment may need to be a key prenatal activity with Healthy Start staff helping the parent to identify family resources or other resources prior to the birth. Limited community resources also are available and application during pregnancy should be encouraged.

The findings of this study also illustrate that Healthy Start should consider that parents require different program interventions about sleeping arrangement and equipment for their infant depending on the availability of a crib for their infant and their beliefs about the best sleeping arrangement for their infant. Four groups were identified by this study among the Healthy Start participants: 1) parents who do not have a crib and are willing to use a crib if available; 2) parents who do not have a crib and do not believe that a crib is necessary because the infant sleeps with the parents, 3) parents who have a crib and use it as the usual sleeping arrangement for their infant; and 4) parents who have a crib but do not use it as the usual sleeping arrangement for their infant.

First, there are the parents who do not have a crib. Of these parents, most do not have a crib because they cannot afford it. The majority (more than 90%) of the Healthy Start parents who did not have a crib reported that they could not afford one. For these parents, the Healthy Start intervention may focus on helping the parents to seek resources during pregnancy to obtain the equipment. These parents also should receive education about safe sleep during pregnancy so that the family knowledge and attitudes will encourage sleeping in the crib once it is obtained. Some parents do not have a crib for their infant because they believe that the infant should sleep in the parents' bed. For these parents', education about safe sleeping arrangements and determining if the parents' bed is merely a "fall-back" arrangement because they don't have the funds for a crib should be explored by Healthy Start staff.

Second, parents with cribs may have different patterns of use. Parents who report that they have a crib and the infant usually sleeps in the crib should receive reinforcement and follow-up. Healthy Start staff should consider follow-up for all parents who have a crib to determine problems in using the crib and changes in use of the crib since the findings showed that having a crib does not result in using it regularly. For these parents, Healthy Start staff should identify reasons for non-use of the crib, offer child development and parenting education, and assist in developing a plan with the parents for safer sleeping arrangements. In some cases, parents and extended family members may have conflicting views of sleeping arrangements and Healthy Start staff may assist parents in a plan for communicating the parents' choice for sleeping arrangement for the infant.

In general, Healthy Start is involved in addressing three areas: the access and availability of equipment and baby products, increasing knowledge about safe sleep and promoting attitudes that are positive toward use of crib use, and providing follow-up services to parents to deal with their concerns about sleeping arrangements and other safety issues and to reinforce positive behavior and attitudes for infant health.

There are no ready solutions for the problem of obtaining infant equipment or products such as diapers for emergency situations. Since Healthy Start funds are not available for infant equipment and availability of products such as diapers are limited, Healthy Start may work as an advocate for participants in more funding for these items as well as providing prenatal interventions for individual participants to encourage the family to obtain a crib during pregnancy through their extended family, friends, donations or gifts. Establishment of the importance of a crib as a necessary item is important during pregnancy. In terms of advocacy, Healthy Start may wish to review programs in other communities to determine if there are

innovative ideas, programs or funds that may be sought for equipment for Healthy Start families. Selected Healthy Start participants with specific medical or behavioral health diagnosis may be eligible for tangible aid from other resources that could be explored.

Once a crib is available for the infant, Healthy Start interventions may follow their health education process of providing information to the parents about safe sleep, positive attitudes toward crib use, and completing follow-up interviews with parents at regular intervals to determine problems with sleeping arrangements as well as emerging problems with having funds to purchase diapers, enrollment in WIC for formula and other needs so as to decrease emergencies as much as feasible.

Finally, the purpose of this study was to determine general trends and to conduct a survey with the least burden on the participant by completing a brief questionnaire. As a result, the findings are more general in nature and should be considered more as a preliminary report of the needs and identification of problems for participants than as a definitive explanation of the issue. The limitations of this study also should be considered. The respondents comprised the participants receiving a home visit during the two-week period of data collection period. All mothers asked to complete the questionnaire participated. Although there is no reason to believe that these participants visited during this data collection period varied in their need for baby items and equipment, behavior and attitudes about sleeping arrangements as compared to other Healthy Start participants, there may be differences that would be determined with more detailed and in-depth data collection. The same cautions pertain to interpretation of findings about individual Healthy Start regions. These findings may assist the program in identifying particular concerns in some communities but more information would be needed to more fully understand the issues and to formulate remedies for each region.

Section IV. RECOMMENDATIONS

A.
The primary recommendations involved the early presentation of the need for baby equipment during the pregnancy, determining parental preferences for sleeping arrangements, providing services and education, and mobilizing more community and family support as feasible. These are difficult problems and the findings again affirm the difficulties of young families in having ongoing access to supplies for their infants and young children.

B.
The findings will be used to seek additional funds for the Healthy Start program.

Section V. IMPACT BASED UPON THE RECOMMENDATIONS/RESULTS OF THE LOCAL EVALUATION

A.
The community perinatal organizations and those involved with the pediatric and child development community also have convened meetings of area providers and interested consumers regarding these needs so this is an ongoing issue in this community. The local

Perinatal Periods of Risk (PPOR) Team also has been instrumental in bringing these issues to public attention.

B.
There have been no immediate changes; seeking additional funding for these needs is ongoing.

Section VI. PUBLICATIONS

N/A

VII. Fetal and Infant Mortality Review (FIMR)

Healthy Start, Inc. and the Allegheny County Health Department Fetal Infant Mortality Review was a process to gain a better understanding of the factors that contributed to infant deaths through the systematic evaluation of individual cases.

During 1994-1995, an in-depth review of infant deaths in the Healthy Start Project Area was completed. Each infant death was reviewed using data collected from birth and death certificates, medical record abstraction, autopsy, and when permitted, maternal home interviews. Funds were provided by the Allegheny County Health Department, Healthy Start, Inc. and the Jewish Health Care Foundation.

The review process involved a two-tiered approach. Summaries of the information collected were first presented to a Technical Review Panel (TPR) comprised of medical professionals. The Technical Review Panel included an obstetrician, a neonatologist, pediatrician, pathologist, coroner, social worker, nurse epidemiologist, and public health administrator. The technical review was conducted in collaboration with Magee Womens Hospital and the University of Pittsburgh, Graduate School of Public Health. The panel identified factors that may have contributed to the infant's death, and made recommendations to prevent future deaths.

Recommendations from the Technical Review Panel were them presented to a Community Review Panel (CRP). The Community Panel included representatives from community hospitals, health and human service agencies, local foundations, community-based non-profits, the Pittsburgh Police and the City and County Housing Authorities, managed care organizations, local, county, state and federal political representatives and the Pittsburgh Public Schools. The task of the Community Panel was to target interventions based on local needs, including policy development and system change and recommend initiatives.

In 1997, the finding and recommendations of both the Technical Review Panel and the Community Review Panel were formally presented to the public. "Healthy Babies….Improving Pregnancy Outcomes; Findings and Recommendations of the Infant Mortality Review Project" was published and distributed to health and human service providers and community groups throughout Allegheny County.

The outcomes from this review provided the basis for many of the current Healthy Start initiatives. In addition, the Allegheny County Child Death Review Team (CDRT) is an outcome of this effort.

VIII. Products

IX. Project Data

See attached folder titled 'Project Data"